

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

FAMIS and FAMIS Moms
Data Book and Capitation Rates
Fiscal Year 2010

Submitted by:

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May 29, 2009

Mr. William Lessard
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Bill:

Re: FY 2010 FAMIS and FAMIS Moms Data Book and Capitation Rates

The enclosed report provides a detailed description of the methodology used for calculating capitation rates for the Virginia Medicaid FAMIS and FAMIS Moms programs for FY 2010. The methods used for calculating these costs are consistent with Centers for Medicare and Medicaid Services and State Children's Health Insurance Program requirements.

Please call Sandi Hunt at 415/498-5365 or Susan Maerki at 415/498-5394 if you have any questions regarding these capitation rates.

Very Truly Yours,

PricewaterhouseCoopers LLP

Sandra S. Hunt

By: Sandra S. Hunt, M.P.A.
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**Virginia Medicaid
FAMIS and FAMIS Moms**

Data Book and Capitation Rates

Fiscal Year 2010

Prepared by PricewaterhouseCoopers LLP

May 2009

PricewaterhouseCoopers LLP (PwC) has calculated capitation rates for the Virginia Family Access to Medical Insurance Security (FAMIS) program and for pregnant woman up to 200% FPL, FAMIS Moms program, for State Fiscal Year 2010. We use data submitted by the contracting health plans to estimate the cost of providing services. The development of these rates is discussed in this report and shown in the attached exhibits.

I. FAMIS Program Rate Development

I.A FAMIS Program Description

The State Children's Health Insurance Program (SCHIP) was promulgated under Title XXI of the Social Security Act through the Balanced Budget Act of 1997. This federal legislation authorized states to expand child health insurance to uninsured, low-income children through either or both a Medicaid expansion and a commercial-like health plan with comprehensive benefits.

Virginia began its SCHIP program, called Children's Medical Security Insurance Plan (CMSIP), in October 1998 modeled on the Medicaid program. The program covered eligible children from birth through age 18 in families with income at or below 185% of the federal poverty level. State Legislation was passed in 2000 to change CMSIP to a more commercially-based model.

The program transitioned to the Family Access to Medical Insurance Security (FAMIS) in August 2001 with health plan enrollment beginning in December 2001.

The FAMIS program covers eligible children from birth through age 18 in families with income at or below 200% of the Federal Poverty Level. Both a centralized eligibility processing unit and Local Departments of Social Services work together to create a "no wrong door" process that simplifies eligibility determination, resulting in a streamlined and shorter application process. A 12-month waiting period for persons who voluntarily dropped health insurance was ultimately reduced to 4 months. Health care services are delivered through managed health care insurance and fee-for-service programs.

The FAMIS benefit package is designed to be equivalent to the benefit package offered to Virginia State employees as of August 2001 and includes expanded well-baby, well-child care, dental, and vision services. Enrollees share in the cost of certain services through limited co-payments similar to commercial health plan practices. The following table shows the schedule of co-payments for children in families above and below 150% federal poverty level.

FAMIS Cost Sharing Requirements By Service		
	Cost Sharing	
	>150% FPL	<=150% FPL
<u>Service</u>		
Office Visit Copay	\$5.00	\$2.00
Specialist Copay	\$5.00	\$2.00
IP Copay/Admit	\$25.00	\$15.00
Rx	\$5.00	\$2.00
Annual Co-payment Maximum	\$350	\$180

As required by Title XXI, cost sharing will not exceed 5% of a family's gross income for families with incomes from 150% to 200% of poverty. Cost sharing will not exceed 2.5% of gross income for families with incomes below 150% of poverty.

I.B. Federal Rate Setting Requirements

Title XXI does not impose specific rate setting requirements on states. Consequently, unlike Medicaid Managed Care programs that operate under Title XIX, states have significant flexibility in their approach to determining appropriate payment rates. Similar to most states, Virginia has chosen to mirror the Medicaid rate setting methodology for FAMIS, with appropriate adjustments to recognize differences in the covered population and the goals of the program. The FAMIS per member per month (PMPM) calculation

relies on the analysis of health plan data submissions for this enrolled population with adjustments that would meet the test of actuarial soundness.

I.C. Data Book

In this section we describe the data available to PwC for developing the capitation rates, the process used for selecting the claims and the individuals that are ultimately included in the rate development process. In addition, adjustments that are made to the data in the early stages of the rate development process are described

The following sources were used for the FAMIS rate setting calculations:

- Department of Medical Assistance Services (DMAS) eligibility information based on capitation payments;
- Health plan claims/encounter data for their FAMIS population;
- Health plan financial data; and
- Other health plan administrative data.

The historical data period is FY 2007 and FY 2008 which covers services incurred during the period from July 1, 2006 to June 30, 2008. These data reported services paid during this two-year period with additional run out for the first four months of FY 2009, to the end of October 2008.

Supplemental health plan data are used for certain portions of the analysis. Specifically, the following health plan data were incorporated:

- Observed trends in utilization and cost per unit of service;
- Capitation arrangements with subcontractors;
- Supplemental payments, such as physician incentives and case management fees, not reflected in the encounter data;
- Prescription drug purchasing arrangements; and
- Health plan administrative costs.

The service categories are those that were developed for the FY 2005 rate setting and further modified for FY 2006. There have been no changes to the service category definitions since that date. These service categories are primarily defined by bill type, CPT code, and revenue code fields in the claims records.

In this summarization process, unit counts were made for each service category. Table 1, Service Unit Definitions, describes the types of units that were counted for each detailed service category. In the table, “Units” indicates the actual unit counts that were recorded on each claim. “Claims” or “Prescriptions” or “Record Counts” refers to a count of “1” for each claim record in the historical database. This count is used for services in which recorded units are not meaningful, such as for pharmacy where the units recorded are often the number of pills dispensed. “Admits” are used for inpatient units, and represent the number of inpatient admits that were paid by the program.

Service Unit Definitions		
Service Category	Unit Count	Multiple Units
DME/Supplies	Claims	
FQHC/RHC	Units	Yes
Home Health Services	Claims	
Inpatient – Maternity	Admits	
Inpatient – Newborn	Admits	
Inpatient – Other Med/Surg	Admits	
Inpatient – Psych	Days	
Lab	Record Count	
Outpatient – Emergency Room	Claims	
Outpatient – Other	Claims	
Pharmacy	Prescriptions	
Professional – Anesthesia	Units	Yes
Professional – Child EPSDT	Units	Yes
Professional – Evaluation & Management	Units	Yes
Professional – Maternity	Units	Yes
Professional – Other	Units	Yes
Professional – Psych	Units	Yes
Professional – Specialist	Units	Yes
Professional – Vision	Units	Yes
Radiology	Record Count	Yes
Transportation	Claims	

The claims and eligibility information used in this report includes data only for FAMIS recipients who are eligible for the program based on their eligibility category and service use during the data period.

FAMIS rates are developed as five rate cells with separate co-payment adjustments.

- **Age.** Capitation rates are paid separately for the following age groups: Under 1, 1-5, 6-14, 15-18 Female, and 15-18 Male.
- **Program.** FAMIS operates as a commercial program, is modeled on the Virginia State Employees health program benefit structure, and includes member co-payment requirements. There are separate rates for those under and over 150% of the Federal Poverty Level.

In the FAMIS rate setting process, historical claims data for the total population, both the $\leq 150\%$ FPL and the $>150\%$ FPL, are combined, adjusted, and trended. The final adjustment reflects the difference in the co-payment schedules for the two income groups. Lastly, the administrative cost factor is applied.

Review of the Health Plan Claims/Encounter Data

The health plan encounter data review was conducted in six major steps.

1. Verification of health plan data submission
2. Edit of records for logical exclusions
3. Edit of records against DMAS capitation payment file
4. Summary of health plan fee-for-service paid claims
5. Addition of capitated and subcontractor services
6. Aggregation of data across all health plans

Review of the health plan data was performed separately for each plan. As a first step, the detailed claims data were converted to summary reports to provide comparison to the data request and confirmation that PwC received the expected data. Information was provided to the health plans regarding record and payment totals for each separate record type (e.g., UB92, CMS1500, pharmacy, subcontractors). The health plan reports also provided a general assessment of data quality, including beginning and end dates of service, the extent of missing variables and confirmation of the interpretation of plan-specific coding and variables in the data sets.

Two sets of edits were applied to each health plan's submitted data. The first edit tested for logical conditions for the historical data period. The logical condition tests and the processing decisions were:

1. Claims that were duplicates, pended or rejected during claims processing were removed.

2. Claims with dates of service outside the FY 2007 to FY 2008 period were removed.
3. Claims with paid amounts of \$0.00 were included if the service was provided under a health plan capitation contract. It was deleted if it was a service that was paid under fee-for-service payment arrangements, as they would contribute no value to the capitation rate development, but would have distorted unit counts.

The second level of edit compared the cleaned health plan claims/encounter records to the eligibility file provided by DMAS. As with the Medallion II rate setting, the DMAS capitation payment file¹, rather than the DMAS eligibility file or the demographic information coded on the claim record, determined whether the claim record was retained. The processing determinations were:

4. Claims matched to member eligibility with missing or invalid demographic or geographic information were removed.
5. Claims for members enrolled in the Medallion II program were removed.
6. Claims matched to FAMIS member eligibility periods outside the FY 2007 to FY 2008 period were removed.
7. Claims identified as paid to freestanding inpatient psychiatric hospitals were removed.
8. Newborns are identified through the standard claims edit process and by comparison to a newborn crosswalk provided by each health plan which permits identification of FAMIS claims incurred by newborns that were originally submitted under the mother's ID number or under a temporary ID.

Each health plan's data was then summarized by service type, the FAMIS rate cell categories for under and over 150% FPL and age-sex. This summarization was done only for those services that were paid by the health plans on a fee-for-service basis. The capitated and subcontractor service dollars and encounter information were added in a second step. Each plan's subcontractor services and payments were reviewed with health plan representatives and appropriate amounts were added to the base data.

¹ The FY 2010 member month count and claim matching process was revised to substitute the DMAS capitation payment file for the DMAS eligibility file as the record of health plan membership and the length of eligibility. Consistent with DMAS operations and the health plan contract terms, a person is assumed to be Medallion II or FAMIS eligible for the full month for which a capitation payment is made.

Individual plan reports were sent to the health plans for review and approval. The reports provided the health plan claims/encounter data, with all adjustments by rate cell.

Inclusion of Health Plan Capitated and Subcontractor Services

The vast majority of the encounter records submitted by each of the health plans were paid under fee-for-service arrangements. The records included both charged and paid amounts and could be readily analyzed.

However, each health plan also had services that were paid, in part or in full, under capitation or subcontractor arrangements. For these services, health plans submitted data in a variety of forms. Each health plan provided a list of services that were provided under such arrangements and the pricing of the services on a PMPM basis. The PMPM amount represented either the actual contractual PMPM paid, or the contractual total dollar payments divided by the covered member months for the time period.

The financial information may or may not have been accompanied by encounter data for those services. All health plans submitted complete claims data for outpatient pharmacy services. Not all of the health plans provided encounter data for laboratory, vision, and mental health, the other service categories that were most often capitated. Therefore, while dollars for the capitated and subcontractor services are incorporated into the historical data, utilization is undercounted and measures such as utilization rates and cost per unit for these services are unreliable.

Behavioral and Mental Health Capitated Subcontractor Services

Capitation payments for behavioral and mental health services were distributed differently than other reported capitated services. Depending on the health plan, mental health services are reported as either FFS paid claims or as capitation amounts for contracted services. In past rate settings, FFS claims were applied to the appropriate inpatient or professional psych service line, but all capitated dollars were included in the Professional-Psych service line with dollars allocated based on the member month distribution between rate cells.

For the health plans that capitate psychiatric services (CareNet and Optima), the capitated mental health data is provided as total dollars or an aggregate PMPM with limited detail by service type (inpatient vs. professional) or program (Medallion II vs. FAMIS). Approximately 45% of mental health dollars are represented by the plans that capitate these mental health services.

We analyzed mental health claims level detail provided by the three plans that do not capitate, Anthem, Virginia Premier, and AmeriGroup, by service type and aid category.

Detailed analysis of the distribution of FAMIS mental health FFS encounter data showed differences in the total PMPM between FAMIS and TANF and the distribution of

inpatient and outpatient services. Overall, the FY 2007 - FY 2008 historical encounter FFS paid claims showed the FAMIS mental health PMPM was approximately two thirds the TANF mental health PMPM, or \$2.31 PMPM compared to \$3.63 PMPM. For FAMIS, the distribution of dollars was 35.3% inpatient and 64.7% professional while the TANF distribution was 49.8% inpatient and 50.2% professional.

The factors developed for the FAMIS population were applied to the CareNet and Optima reported mental health capitation payments to derive the FAMIS mental health PMPM and to modify the individual historical data reports for the health plans that capitate mental health services. The modified reports were then aggregated for the historical data.

Historical Health Plan Encounter Data

The resulting historical claims and eligibility data were tabulated by service category and are shown in Exhibit I.1, generally referred to as the “Data Book”. These exhibits show unadjusted historical data, with the exception of the adjustments described above, and are the basis of all future calculations described here. These exhibits show, for informational purposes:

- Member months for fiscal years 2007 and 2008;
- Total dollar value of claims and capitated services for fiscal years 2007 and 2008; and
- Costs per member per month (PMPM) for fiscal years 2007 and 2008.

I.D Capitation Rate Calculations

The capitation rates for FY 2010 are calculated based on the historical data shown in Exhibit I.1 adjusted to reflect changes in payment rates and covered services. Each adjustment to the historical data is described in the following section. The adjustments are applied to the historical data and resulting capitation rates are presented in Exhibits I.5a and I.5b.

The steps used for calculating the capitation rates are as follows:

1. The combined FY 2007 and FY 2008 historical data for each rate cell and service category are brought forward to Exhibit I.4 from the corresponding rate cell in Exhibit I.1. This information serves as the starting point for the capitation rate calculation.
2. A number of changes in covered services and payment levels have been mandated by the Virginia State Legislature. Each of these adjustments, as well as adjustments for other services not included in the source data, is described in detail below under Section I.E, and is shown in Exhibits I.2a – I.2j.

3. The claims data are adjusted to reflect the expected value of Incurred But Not Reported (IBNR) claims and to update the data to the FY 2008 contract period. These adjustments are described in Section I.F and are shown in Exhibit I.3. The resulting claims are shown in Exhibit I.4 under the column “Completed & Trended Claims”.
4. The adjusted claims costs from Step 3 are divided by the count of member months for each rate cell (from Exhibit I.1) to arrive at preliminary PMPM costs by service category.
5. The PMPM costs are summarized by rate cell across all service categories to arrive at the cost for each rate cell.
6. An adjustment is made to reflect the differences in the co-payment schedule applicable to FAMIS members below and above 150% of the Federal Poverty Level. Co-payment adjustments are made for major service categories; they are not added for all individual claims as health plans may require different collection of co-payments.
7. An adjustment is made to reflect average health plan administrative costs plus a 0.5% contribution to reserves. The derivation of this value is included in the Adjustments described in Section I.E.
8. An additional adjustment is applied to limit the FY 2009 - FY 2010 annual increase to the budget cap imposed by the state legislature.

1.E. FAMIS Legislative and Program Adjustments

Legislation and policy changes in the FAMIS program for FY 2007 and later must be reflected in the development of per capita rates, as the data used to develop rates do not fully include the effect of those changes.

The historical data presented in Exhibit I.1 is adjusted by the policy and program factors described in this section (Exhibits I.2a to I.2k) and the Trend and IBNR factors (Exhibit I.3).

Pharmacy Adjustment

The outpatient prescription drug adjustment is based on FAMIS health plan data, taking into consideration aspects of pharmacy management reported by the health plans. The calculation uses health plan data, with factors for rebates, and Pharmacy Benefit Management (PBM) fees, to determine an adjusted PMPM amount.

The final pharmacy adjustment factors are shown in Exhibit I.2a. The PBM factor is a reduction of -3.4%.

Evaluation and Management Professional Fee Increase Adjustment

The adjustment passes through the 10% increase for the pediatric population, effective July 1, 2007, and is applied to the half the base period. Emergency Department codes are excluded from these increases.

The adjustment is shown in Exhibit I.2b and applied to the total historical claims data in Exhibit I.4 under the column labeled “Other Adjustments”.

Professional Fee Increase Adjustment (Excluding Pediatric and OB-GYN)

The adjustment passes through the FFS increase of 5% for all remaining professional services for FY 2008, effective July 1, 2007. This increase excludes pediatric E&M services that were subject to increases in the fee schedule that are incorporated as previously described adjustments.

This adjustment is shown in Exhibit I.2c and is applied to half of the base period to Professional-E&M, Professional-Specialist and All Other Professional service lines in Exhibit I.4 under the column labeled “Other Adjustments”.

Exempt Infant Formula Carveout Adjustment

DMAS altered its policy regarding reimbursement of selected formula for infants with diseases of inborn errors of metabolism and now requests direct billing for those services. Historically, the health plans referred members to the Woman, Infants, and Children (WIC) program for these services, but paid for services after the WIC benefit maximum is reached. This adjustment removes the amount that the health plans paid for selected formulas after children up to age 19 have met the WIC cap. For FY 2007, the exempt formula adjustment was applied to children up to age 6; for FY 2008 and after, it is applied to all children up to age 19. DMAS provided a list of HCPCS codes to identify the exempt formula services.

The value of these services has been removed for FAMIS children up to age 19 and is shown in Exhibit I.2d. The adjustment is applied to the DME/Supplies service line in Exhibit I.4 under the column labeled “Other Adjustments”.

Other Immunizations

The Center for Disease Control and Prevention (CDC) issued updated and new recommendations for pediatric and adolescent immunizations that were effective for January 1, 2007. The FY 2010 adjustment is applied to the first six months of base period, July 1, 2006 to December 31, 2006. Administration and serum costs must be paid by the health plan; serum costs are updated for the DMAS serum fee schedule effective July 1, 2008.

CDC recommendations that went into effect during the historical data period used for the rate setting include:

1. The new rotavirus vaccine is recommended in a 3-dose schedule at ages 2, 4, and 6 months.
2. The influenza vaccine is now recommended for all children aged 6-59 months. Previously the recommendation extended only to children aged 6-59 months with certain risk factors.
3. Varicella vaccine recommendations are updated. The first dose should be administered at age 12-15 months, and a newly recommended second dose should now be administered at age 4-6 years.
4. Meningococcal vaccine is recommended for all children at the 11-12 year old visit, as well as for unvaccinated adolescents at high school entry (15 years of age).

The adjustment assumes that: 1) The new recommendations can be accommodated within the current pediatric and adolescent vaccination schedules and new costs include both serum and administration, 2) Health plans will achieve compliance rates comparable to those reported to DMAS on the EQRO reports. This is 68% for children 2 years old and 34.5% for adolescents. The 68% compliance rate was assumed applicable for children up to 6 years old, but has been adjusted on the assumption that health plans began efforts to meet the new recommendations as of January 1, 2007, and 3) The distribution of ages within a rate cell is equal.

Based on these assumptions, we estimate that the value of a new immunization schedule adjustment ranges from 1.3% to 2.0% of the Professional-E&M service line, depending on rate cell. This adjustment is shown in Exhibit I.2e and is applied to the Professional-E&M service line in Exhibit I.4 under the column labeled "Other Adjustments".

HPV Vaccine Adjustment

The HPV vaccine has been demonstrated to reduce the risk of the most common causes of cervical cancer. The Centers for Disease Control and Prevention (CDC) recommends that females receive the human papillomavirus (HPV) vaccine beginning at age nine (9). The DMAS Medicaid program began to cover the HPV vaccine in December 2007. For the FAMIS population, the health plans are responsible for the cost of the serum and administration. The vaccine became mandatory for girls who are at least 11 years old entering school beginning October 1, 2008. For females aged 19 and under, the target penetration rate is assumed to be 25% with a cost of \$130.27 for each of the three doses in the HPV series.

Actual utilization experience of the HPV vaccine has been lower than the utilization estimated for prior rate setting. This appears to be due to a combination of lower than expected overall acceptance and the fact that many females did not complete the series of three vaccinations. For the FY 2010 rate setting, the target penetration rate is assumed to

be 12.5% for females aged 19 years and under, at a cost of \$11 for administration of each of the three doses in the HPV series and a total serum cost of \$390.81. These assumptions are applied to the female 6-18 population in the relevant aid category and age cells and are estimated to affect 7.5% of the total rate cell members.

These assumptions are applied to the female population in the relevant rate cells, resulting in an adjustment of 1.4%. This adjustment is shown in Exhibit I.2f and is applied to the Professional-E&M service line in Exhibit I.4 under the column labeled “Other Adjustments”.

Hospital Inpatient Adjustments

The hospital inpatient adjustment factor reflects legislative reductions for FY 2009 and FY 2010. The adjustment factor is calculated relative to the 78% operating cost base that was in place for FY 2007 - FY 2008. For FY 2009, the 78% was reduced by 2.683%. The adjustment is developed using the 78% of cost and applied to an operating component estimated at 90%. There is also a unit cost freeze legislated for FY 2010. Based on inpatient cost trend for Virginia, this rate freeze reduces the operating cost component by an additional 4.03%.² An additional FY 2010 reduction is a capital reimbursement rate reduction from 80% to 75% of cost, which is applied to the capital component estimated at 10%. The capital cost reduction excludes the three hospitals in the state with more than 50% of Medicaid admissions (Virginia Medical College, University of Virginia Hospital and Children's Hospital of the Kings Daughters) was calculated based on the historical proportion in the total FAMIS inpatient claims.

There is a separate adjustment for inpatient psychiatric services provided in psychiatric units of general medical acute care hospitals.³ The inpatient psychiatric adjustment factor is developed using the increase from 78% in FY 2007 to an 84% operating cost base for FY 2008. For FY 2009, the 84% was reduced by 2.683% and is also subject to the FY 2010 unit cost freeze. The inpatient psych adjustment also assumes a capital cost component of 10.0%. The inpatient psychiatric factor is applied to mental health claims that are submitted with encounter detail and the allocated mental health inpatient subcapitation payments.

These adjustment factors are shown in Exhibit I.2g and applied to all hospital inpatient service categories in Exhibits I.4 under the column labeled “Other Adjustments”.

Rural Wage Index Adjustment

This adjustment eliminates the rural wage index hospital factor. DMAS provided estimates of the value of the increase for the two regions that are affected, Other MSA,

² This is applied as a policy adjustment in Exhibit 2g rather than as a reduction to the cost per unit trend in Exhibit I.3.

³ Freestanding psychiatric hospitals and state psychiatric hospitals are excluded..

and Rural. Because FAMIS rates are developed at the statewide level, an adjustment factor was calculated based on a ratio of the estimated increase and the statewide Medallion II Inpatient-Other service line. This is the same adjustment as used in the FY 2009 rate setting.

This adjustment factor is shown in Exhibit I.2h and applied to the Inpatient-Other service category in Exhibit I.4 under the column labeled “Other Adjustments”.

Provider Incentive Adjustment

The Provider Incentive Payment Adjustment takes into consideration the various ways that health plans provide incentive payments to providers for coordinating care and ensuring access. Depending on the plan, this can be done through an increase in provider fee schedules, payment of case management fees, and/or provider incentive programs. To the extent that it has been used to increase professional fee schedules, the amount is already included in the claims and encounter data. Some plans reported the case management and incentive amounts as capitation payments. To avoid double counting, we did not include the value of the capitation amounts that plans reported as representing those payments in the base data. Their value has been incorporated into the Provider Incentive Payment Adjustment.

This adjustment represents the percentage value of the case management and provider incentive payments that are paid separately from the encounter data. The value of the FAMIS incentive is \$3.57 PMPM. Because of the small FAMIS base, this translates to 2.9% of the weighted average PMPM medical cost. This percentage is shown in Exhibit I.2i and is presented as the dollar value applicable to the rate cell in the line labeled Provider Incentive Payment Adjustment in Exhibit I.4.

Plan Administration Adjustment

The CMS regulations require that administrative costs directly related to the provision of Medicaid State Plan approved services be incorporated into the rate setting process. Each health plan provided revenue and administrative cost data for calendar year 2008, consistent with the information provided to the Virginia Bureau of Insurance on the required form entitled *Analysis of Operations by Lines of Business*, and as necessary, notes to interpret the financial figures. We also received the *Underwriting and Investment Exhibit, Part 3, Analysis of Expenses*. Separately, plans provided third and fourth quarter results for their Medicaid and S-CHIP (FAMIS) lines of business in order to evaluate the impact of the FY 2009 rates that went into effect in July 2008.

For FY 2010, there is a change in how the administrative allowance is trended and applied. In past rate setting, the administrative component was calculated as a percentage of the adjusted and trended medical cost data in Exhibit I.4. This method trends the administrative adjustment factor with the weighted average medical trend and results in an administrative dollar PMPM that varies for each rate cell.

The revised methodology develops an administrative dollar PMPM that is then converted to a percentage. We use the same source of data to develop the historical administrative PMPM and subtract the self reported disallowed costs. These were valued at 0.09% of the administrative expense. The administrative dollar PMPM is then apportioned across the four eligibility groups enrolled in the Virginia Medicaid managed care programs - ABAD, TANF, FAMIS and FAMIS MOMS using the ratio of the adjusted and trended medical PMPM for each aid group. The CY 2008 FAMIS administrative PMPM is \$8.55.

Using the breakdown of administrative expenses from the BOI reports, the salary and all other general administrative components of the historical PMPM are separately trended to the FY 2010 contract period. The salary component is trended using the Bureau of Labor Statistics 2008 calendar year employment cost trend for total compensation, private industry, management, business and financial services. The non-salary administrative component and the Claims Adjustment expense components are trended using the 2008 calendar year Consumer Price Index for All Urban Consumers (CPI-U).

The trended value is then increased by a 0.75% contribution to reserves. The allowance for a contribution to reserve has been increased from 0.5% in last year's rate setting to 0.75% for FY 2010. This change offsets a reduction in health plan invested assets due to the change in the capitation payment date from the beginning of the month to the end of the month.

The trended value of the administrative factor is \$8.88. This value is converted to an administrative allowance percentage of the base capitation rate, a value of 6.54%. The contribution to reserves is added to determine the final administrative factor of 7.29%.

The administrative cost factor is applied to the total adjusted and trended claims amount for each rate payment category. This adjustment factor is applied in the final step of the per capita cost calculations after the application of the co-payment adjustment in Exhibit I.5a.

State Budget Cap Adjustment

The Virginia State Legislature limited the annual increase in the DMAS managed care programs to 7%. Subsequent legislation directed that this increase cap be reduced by the value of the hospital inpatient fee reductions described in Exhibits I.2g and I.2h. The calculated rate, after adjustments and trend, exceeded the 7% limit and therefore the state budget cap is applied. The value of the hospital fee reductions is 0.72%, reducing the state budget cap to 6.28%. The factor to reduce the adjusted and trended data to the 6.29% limit is shown in Exhibit I.2k and is applied after the copayment and administrative cost adjustments in Exhibit I.5a.

I.F. FAMIS Trend and IBNR Adjustments

The data used for the calculations reflects experience in the Virginia FAMIS program from FY 2007 through FY 2008. These data must be adjusted to reflect the contract period of FY 2010 through the application of trend rates that reflect changes in payment levels and utilization rates between the data period and the contract period. In addition, the claims data are not 100% “complete” in that some cost information is not available in the claims databases provided. Incomplete data results from the time lag between when services are provided and claims are fully paid. The amount of incomplete claims is referred to as Incurred But Not Reported (IBNR) and can be measured through actuarial models.

Trend and IBNR adjustment factors were developed using monthly historical health plan expenditures for FY 2006 to FY 2008; two years of data are used to develop the historical data period trend and a longer period, three years of data, are used to develop the projection contract period trend.

The historical data were evaluated using a PricewaterhouseCoopers model that calculates IBNR amounts using a variety of actuarially accepted methods, and calculates trend using a least-squares regression methodology. FAMIS trend and IBNR factors were developed separately for the following service categories: Inpatient Medical/Surgical, Inpatient Psychiatric, Outpatient Hospital, Practitioner, Prescription Drug, and Other. The underlying data were adjusted for calculation of the inpatient hospital trend factors to incorporate the impact due to the DMAS increase in the hospital inpatient operating adjustment factor that occurred during the historical period.

Trend rates must be applied to move the historical data from the midpoint of the data period (July 1, 2007) to the midpoint of the contract period (January 1, 2010), or two and half years (30 months). Data period trend rates for these groups are developed from a regression analysis on the 24 months of historical Virginia health plan data used for these capitation rates. Contract period trend rates are adjusted to reflect our best estimate of trend in the future and are based on the three year historical trends where appropriate. Where we considered the historical trend experience to be an unreliable indicator of future trend, we examined the additional data provided by the plans, estimates of cost increase provided by DMAS, and other sources, as well as the overall rate of change to derive the recommended trend assumptions.

For inpatient hospital, a small number of high cost inpatient claims affected the trend calculation. For trend analysis only, approximately 80 claims over \$25,000 per claim were truncated over the three year period. Total payment for these claims is retained in the historical data presented in Exhibit 1.

Evaluation and presentation of FAMIS trend factors matches changes made in FY 2009 for the Medallion II report. Data period trend was evaluated using the base year FY 2007

and FY 2008 data. Total data period PMPM trend is derived from separate consideration of utilization and cost per unit trend. Contract period trend was developed by reviewing the past three years (FY 2006 - FY 2008) of paid claims data. Both were evaluated with adjustments for increases in the Medicaid FFS fee schedule during the base years to the extent they were significant.

Table 1 provides a summary of the adjustments applied to the data used for contract period trend before the regression analysis. The professional adjustment reflects the impact of four fee increases, ER Professional, Pediatric E&M, and Adult E&M., The Acute and Psych Hospital Inpatient factors reflect changes in the DMAS operating cost base during the historical period. There are no underlying adjustments made before evaluation of Hospital Outpatient or Pharmacy.

ADJUSTMENTS PRIOR TO TREND ANALYSIS		
Service	FY	ALL FAMIS
Professional	FY06	1.1083
	FY07	1.0525
	FY08	1.0000
Hosp Inpt	FY06	0.9989
	FY07	0.9758
	FY08	0.9758
Psych Inpt	FY06	1.0681
	FY07	1.0432
	FY08	1.0432

Incurred But Not Reported (IBNR) completion factors in the first column of Exhibit I.3 are applied to the total claims in the first column of Exhibit I.4, and the dollar value of the IBNR completion factors are shown in the second column of that exhibit. The data used in this analysis has run out through October 2008, or four months past the end of the data reporting period, and the resulting IBNR factors are generally small. IBNR factors for Inpatient Medical/Surgical, Inpatient Psychiatric, Outpatient Hospital, Practitioner, Prescription Drug and Other services are all set to 0.5% or less.

The second column of Exhibit I.3 provides information on the cumulative impact of the policy and program adjustments in Exhibits I.2a - I.2j. This is for information purposes and should be evaluated in conjunction with the IBNR and applied trend.

Utilization and cost trend are presented separately for the data period and as a combined trend for the contract period. Overall, the data period trend is somewhat higher than the contract period trend. The Total Trend rates are calculated using compound interest

calculations as a combination of the data period and contract period trends multiplied by (1 + IBNR factor).

The resulting trend factors are shown in Exhibit I.3. These trend and IBNR factors are applied to the historical data in Exhibit I.4 by applicable service category.

I.G Capitation Rates for FAMIS

Adjustment for FAMIS Co-payment Schedule

The FAMIS benefit package includes the collection of member co-payments for inpatient admissions, physician office visits, and outpatient pharmacy services. Each plan was surveyed for the FY 2008 rate setting to determine how these co-payments were administered in their program, and FAMIS copayments have not changes since that time. Using this information, the historical data for each plan was increased separately for the under and over 150% FPL populations by the value of the co-payments. The total value of the co-payments was added to the historical claims base to arrive at a total cost of services. The co-payment adjustment was applied for major service categories. There are some differences in plan co-payment schedules, such as variation between medical supplies and DME co-payments, which are not applied because of insufficient information or lack of claims detail.

The final step in developing the capitation rates for FAMIS is to adjust the combined base rates for the under 150% FPL and over 150% FPL. This was done through a factor that valued the differences in the co-payment amount for separate categories relative to the average utilization of the entire FAMIS population. The separate under 150% FPL and over 150% FPL co-payment adjustment values for medical services for each age-sex cell is shown under the columns Copay Value FAMIS<=150% and Copay Value FAMIS >150% in Exhibit I.5a. These values are subtracted from the medical component of the base rate.

The co-payment adjustments for FY 2010 are very similar to those that were applied to the FY 2009 FAMIS rate setting. The Copay Value PMPM is subtracted from the combined base rate in Exhibit I.5a.

The administrative factor is then applied to the medical component of the capitation rate to produce the statewide FAMIS rates. The FAMIS base rates, with the copayment and administrative adjustment, are then subject to the state budget cap factor described in Exhibit I.2k. The resulting values are shown in the last two columns of Exhibit I.5a.

Exhibit I.5b is the summary comparison of FY 2009 and FY2010 FAMIS rates. Average statewide FAMIS <=150% FPL rates increase 5.55% and average statewide FAMIS >150% FPL rates increase 6.51%, with a weighted average increase of 6.28%.

The policy interpretation of the Virginia legislative language is that the budget cap applies to the payment rates for FAMIS and FAMIS MOMS as a combined program. Therefore the FAMIS MOMS rate development is described in Section II and the final rates are presented in Section III.

II. FAMIS Moms Program Rate Development

II.A Background

Authorization and Program Description

The 2004-2005 Virginia Legislature budgeted funding for a program “to expand prenatal care, pregnancy-related services, and 60 days of post-partum care under FAMIS to an annual estimated 380 pregnant women who are over the age of 19 with annual family income less than or equal to 150 percent of the federal poverty level”. It is also expected that a small number of women, aged 10 to 19, who are not eligible and enrolled in FAMIS, may qualify for the program once they become pregnant.

DMAS, as the agency responsible for implementing the program, interprets the legislative intent of FAMIS MOMS to provide full Medicaid benefits for pregnant women to the covered Federal Poverty Level (FPL) through the S-CHIP program. Full Medicaid benefits for pregnant women include all services, except dental, and include non-emergency transportation, which is not a covered benefit for FAMIS children. Pregnant women who are under age 21 are also eligible for EPSDT-related services. The provision of full Medicaid benefits also means that, in contrast to the FAMIS program for children, there are no co-payments for services.

There have been eligibility income expansions in each year of the FAMIS MOMS program. The schedule of the income expansions is:

FAMIS MOMS Income Eligibility	
Federal Poverty Level	Effective Date
133-150% FPL	August 1, 2005
133-166% FPL	September 1, 2007
133-185% FPL	July 1, 2008
133-200% FPL	July 1, 2009

Eligibility begins with a determination of pregnancy and income verification and continues through the month of delivery, plus an additional two months. One important difference between Medicaid for pregnant women (under either fee-for-service (FFS) or Medallion II) and FAMIS MOMS is that Medicaid offers up to three months of retro active coverage while the FAMIS MOMS' effective date of coverage is the first of the month that the signed application was received. There is no retroactive coverage for FAMIS MOMS enrollees.

Eligible women are enrolled in managed care plans wherever possible. If a woman's FFS OB-GYN participates with one of the available managed care organizations (MCO),

DMAS will transition her into that MCO to provide continuity of care. However, similar to Medicaid rules, a woman can opt out of an MCO if she is in her last trimester and her regular OB-GYN does not participate with the MCO.

II.B Data Book

Approach to Rate Setting for FAMIS MOMS

The FY 2010 FAMIS MOMS rate setting uses MCO data for the period FY 2007 and FY 2008, the period from July 1, 2006 to June 30, 2008. Because the FAMIS MOMS program began in August 2005, this is the first rate setting year that a full two-year data period of cost and utilization information is available. However the number of FAMIS MOMS beneficiaries and member months remains small relative to the size of a similar TANF population. Enrollment in FAMIS MOMS was less than 500 per month in FY 2007 and about 800 per month in FY 2008.

PwC has used the available health plan encounter and claims data for a similar TANF population, program category PD-91, in conjunction with the available FAMIS MOMS data, to develop rates for FAMIS MOMS. All data used in the rate setting is from the MCO encounter data submission; We believe the health plan data provides the most appropriate view of expected costs for the women enrolled in this program.

In developing proposed capitation rates, a key consideration is the method by which women will be enrolled in the health plan and the potential variation in the length of plan enrollment. A very small difference in the average length of plan enrollment can have a material difference in the capitation rate, since most of the cost is incurred at the time of delivery and is not evenly spread over the entire pregnancy and eligibility period.

An analysis conducted for the FY 2006 FAMIS MOMS rate setting period examined two subsets of pregnant women enrolled in the health plans (Program Designation 91 and Other TANF Pregnant Women) and found significant differences in cost, largely because the average length of health plan enrollment for those who enter the program with a confirmed pregnancy was about one third the length of enrollment for those enrolled in the MCOs before they became pregnant.

This difference in average length of enrollment supported the conclusion that the PD91 aid category is the most appropriate population to use for FAMIS MOMS rate setting. The PD91 historical data was also reviewed for differences in cost and utilization for the populations Under 21 and Over 21 years of age. Differences between the two populations, including EPSDT services, were considered insignificant. Therefore, the historical data uses the MCO TANF PD91 population, age 10 and over. Review of the FY 2007 and FY 2008 FAMIS MOMS data supports this conclusion. Although the limited FAMIS MOMS data for FY2007 indicates slightly shorter average length of enrollment and a somewhat

higher PMPM, in the FY 2008 data, length of enrollment and base claims PMPM are essentially similar.

Development of the Data Book for FAMIS MOMS rate setting follows the same methodology described for the FAMIS program earlier in this report, including use of the DMAS capitation payment file to determine eligibility, claims matching and inclusion of subcapitated services.

1.C FAMIS MOMS Legislative and Program Adjustments

Changes in the FAMIS program due to legislation and policy changes for FY 2007 and later must be reflected in the development of per capita rates, as the data used to develop rates does not fully include the effect of those changes. These are described in the following section.

The historical data presented in Exhibit II.1 is adjusted by the policy and program factors described in this section (Exhibits II.2a to II.2h) and the Trend and IBNR factors (Exhibit II.3).

Pharmacy Adjustment

The outpatient prescription drug adjustment is based on FAMIS MOMS and TANF PD91 health plan data, taking into consideration aspects of pharmacy management reported by the health plans.

The calculation uses health plan data, with factors for rebates, and Pharmacy Benefit Management (PBM) fees, to determine an adjusted PMPM amount.

The final pharmacy adjustment factors are shown in Exhibit II.2a. The PBM factor is a reduction of -3.1%.

Evaluation and Management Professional Fee Increase Adjustment

The adjustment passes through the 10% increase for the pediatric population in FY 2008, effective July 1, 2007, which is applied to half the base period. Emergency Department codes are excluded from these increases.

The adjustment is shown in Exhibit II.2b and applied to the total historical claims data in Exhibit II.4 under the column labeled "Other Adjustments".

Professional Fee Increase Adjustment (Excluding Pediatric and OB-GYN)

The adjustment passes through the FFS increase of 5% for all remaining professional services for FY 2008, effective July 1, 2007. This increase excludes pediatric E&M and the OB-GYN services that were subject to increases in the fee schedule that are incorporated as previously described adjustments.

This adjustment is shown in Exhibit II.2c and is applied to half of the base period to Professional-E&M, Professional-Specialist and All Other Professional service lines in Exhibit II.4 under the column labeled “Other Adjustments”.

Exempt Infant Formula Carveout Adjustment

DMAS altered its policy regarding reimbursement of selected formula for infants with diseases of inborn errors of metabolism and now requests direct billing for those services. The health plans have referred members to the Woman, Infants, and Children (WIC) program for these services, but have paid for members after the WIC benefit maximum is reached. This adjustment removes the amount that the health plans pay for selected formulas after children up to age 19 have met the WIC cap. For FY 2007, the exempt formula adjustment was applied to children up to age 6; for FY 2008, it is applied to all children up to age 19. DMAS provided a list of HCPCS codes to identify these services.

The value of these services has been removed for FAMIS MOMS newborns and is shown in Exhibit II.2d. It is applied to the DME/Supplies service line in Exhibit II.4 under the column labeled “Other Adjustments”.

Other Immunizations

There is no other immunization adjustment for the FAMIS MOMS program because newborns are covered up to a maximum of three months; most FAMIS MOMS newborns are assumed to be Medicaid or FAMIS eligible and will receive their immunizations as part of the benefits of those programs.

HPV Vaccine Adjustment

There is no human papillomavirus (HPV) vaccine adjustment for the FAMIS MOMS program because the vaccine is contraindicated for pregnant women.

Hospital Inpatient Adjustments

The hospital inpatient adjustment factor reflects legislative reductions for FY 2009 and FY 2010. The adjustment factor is calculated relative to the 78% operating cost base that was in place for FY 2007 and FY 2008. For FY 2009, the 78% was reduced by 2.683%. The adjustment is developed using the 78% of cost and applied to an operating component estimated at 90%. There is also a unit cost freeze legislated for FY 2010. Based on inpatient cost trend for Virginia, this rate freeze reduces the operating cost component by an additional 4.03%.⁴ An additional FY 2010 reduction is a capital reimbursement rate reduction from 80% to 75% of cost, which is applied to the capital component estimated at 10%. The capital cost reduction excludes the three hospitals in the state where Medicaid represents more than 50% of admissions (Virginia Medical College, University of

⁴ This is applied as a policy adjustment in Exhibit 2e rather than as a reduction to the cost per unit trend in Exhibit I.3.

Virginia Hospital and Children's Hospital of the Kings Daughters) and was calculated based on the historical proportion in the total FAMIS MOMS inpatient claims.

There is a separate adjustment for inpatient psychiatric services provided in psychiatric units of general medical acute care hospitals.⁵ The inpatient psychiatric adjustment factor is developed using the increase from 78% in FY 2007 to an 84% operating cost base for FY 2008. For FY 2009, the 84% was reduced by 2.683% and is also subject to the FY 2010 unit cost freeze. The inpatient psych adjustment also assumes a capital cost component of 10.0%. The inpatient psychiatric factor is applied to mental health claims that are submitted with encounter detail and the allocated mental health inpatient subcapitation payments.

These adjustment factors are shown in Exhibit II.2e and applied to all hospital inpatient service categories in Exhibits II.4 under the column labeled "Other Adjustments".

Rural Wage Index Adjustment

This adjustment eliminates the rural wage index hospital factor. DMAS provided estimates of the value of the increase for the two regions that are affected, Other MSA, and Rural. Because FAMIS rates are developed at the statewide level, an adjustment factor was calculated based on a ratio of the estimated increase and the statewide Medallion II Inpatient-Other service line.

This adjustment factor is shown in Exhibit II.2f and applied to the Inpatient-Other service category in Exhibit II.4 under the column labeled "Other Adjustments".

Provider Incentive Adjustment

The Provider Incentive Payment Adjustment takes into consideration the various ways that health plans provide incentive payments to providers for coordinating care and ensuring access. Depending on the plan, this can be done through an increase in provider fee schedules, payment of case management fees, and/or provider incentive programs. To the extent that it has been used to increase professional fee schedules, the amount is already included in the claims and encounter data. Some plans reported the case management and incentive amounts as capitation payments. To avoid double counting, we did not include the value of the capitation amounts that plans reported as representing those payments in the base data. Their value has been incorporated into the Provider Incentive Payment Adjustment.

This adjustment represents the percentage value of the case management and provider incentive payments that are paid separately from the encounter data. The value of the FAMIS MOMS incentive is \$4.03 PMPM. Because of the relatively high FAMIS base, this translates to 0.5% of the weighted average PMPM medical cost. The amount is

⁵ Freestanding psychiatric hospitals and state psychiatric hospitals are excluded.

similar in dollar value and as a percent compared to the provider incentive factor in the FY 2009 FAMIS health plan rates. This percentage is shown in Exhibit II.2g and is presented as the dollar value applicable to rate cell in the line labeled Provider Incentive Payment Adjustment in Exhibit II.4.

Plan Administration Adjustment

The administrative allowance for FAMIS MOMS is calculated using the same revised approach that was used to develop the administrative allowance for the FAMIS program. The CY 2008 FAMIS MOMS administrative PMPM is \$51.61. The salary and all other general administrative components of this historical PMPM are separately trended to the FY 2010 contract period value of \$53.60 PMPM.

This value is converted to an administrative allowance percentage of the base capitation rate, a value of 6.54%. The 0.75% contribution to reserves is added to determine the final administrative factor of 7.29%

This adjustment factor is applied in the final step of the per capita cost calculations after the application of the co-payment adjustment in Exhibit II.5a.

I.D. FAMIS MOMS Trend and IBNR Adjustments

The data used for the calculations reflects experience in the Virginia FAMIS MOMS program and the health plan TANF PD1 population from FY 2007 through FY 2008. These data must be adjusted to reflect the contract period of FY 2010 through the application of trend rates that reflect changes in payment levels and utilization rates between the data period and the contract period. In addition, the claims data are not 100% “complete” in that some cost information is not available in the claims databases provided. Incomplete data results from the time lag between when services are provided and claims are fully paid. The amount of incomplete claims is referred to as Incurred But Not Reported (IBNR) and can be measured through actuarial models.

Trend and IBNR adjustment factors were developed using monthly historical health plan expenditures for FY 2006 to FY 2008. The historical data were evaluated using a PricewaterhouseCoopers model that calculates IBNR amounts using a variety of actuarially accepted methods, and calculates trend using a least-squares regression methodology. FAMIS MOMS trend and IBNR factors were developed separately for the following service categories: Inpatient Medical/Surgical, Inpatient Psychiatric, Outpatient Hospital, Practitioner, Prescription Drug, and Other. We have adjusted the underlying data for calculation of the inpatient hospital trend factors to incorporate the impact due to the DMAS increase in the hospital inpatient operating adjustment factor that occurred during the historical period.

Trend rates must be applied to move the historical data from the midpoint of the data period (July 1, 2007) to the midpoint of the contract period (January 1, 2010), or two and half years (30 months). Data period trend rates for these groups are developed from a regression analysis on the 24 months of historical Virginia health plan data used for these capitation rates. Contract period trend rates are adjusted to reflect our best estimate of trend in the future and are based on the three year historical trends where appropriate. Where we considered the historical trend experience to be an unreliable indicator of future trend, we examined the additional data provided by the plans, estimates of cost increase provided by DMAS, and other sources, as well as the overall rate of change to derive recommended trend assumptions. We have revised the evaluation and presentation of trend factors to match the presentation in the Medallion II report. Data period trend was evaluated using FY2007 and FY2008, the base year data. Total data period PMPM trend is derived from separate consideration of utilization and cost per unit trend. Contract period trend was developed by reviewing the past three years (FY 2006 - FY 2008) of paid claims data. Both were evaluated with adjustments for increases in the Medicaid FFS fee schedule during the base years to the extent they were significant.

Table 1 provides a summary of the adjustments applied to the data used for contract period trend before the regression analysis. The professional adjustment reflects the impact of four fee increases, ER Professional, Pediatric E&M, and Adult E&M. The Acute and Psych Hospital Inpatient factors reflect changes in the DMAS operating cost base during the historical period. There are no underlying adjustments made before evaluation of Hospital Outpatient trend. For Pharmacy, there is no adjustment for the data period trend evaluation. However, we note that 82% of prescriptions in FY 2008 were generic, an increase from 77% generic in FY 2007. We believe that the negative cost trend in the data period is due to this increase. On the assumption that the 82% approaches the maximum expected generic penetration, pharmacy contract period trend was evaluated by modifying the historical trend to reflect the FY 2008 generic-brand mix.

ADJUSTMENTS PRIOR TO TREND ANALYSIS		
Service	FY	ALL FAMIS
Professional	FY05	1.0923
	FY06	1.0669
	FY07	1.0000
Hosp Inpt	FY05	0.9989
	FY06	0.9758
	FY07	0.9758
Psych Inpt	FY05	1.0681
	FY06	1.0432
	FY07	1.0432

Incurred But Not Reported (IBNR) completion factors in the first column of Exhibit II.3 are applied to the total claims in the first column of Exhibit II.4 and the dollar value of the IBNR completion factors are shown in the second column of that exhibit. Since the data used in this analysis has run out through February 2008, or eight months past the end of the data reporting period, the resulting IBNR factors are generally small. IBNR factors for Inpatient Medical/Surgical, Inpatient Psychiatric, Outpatient Hospital, Practitioner, Prescription Drug and Other services are all set to 0.5% or less.

The second column of Exhibit II.3 is information on the cumulative impact of the policy and program adjustments in Exhibits II.2a - II.2h. This is for information purposes and should be evaluated in conjunction with the IBNR and applied trend.

Utilization and cost trend are presented separately for the data period and as a combined trend for the contract period. Overall, the data period trend assigned is somewhat lower than the contract period trend. The Total Trend rates are calculated using compound interest calculations as a combination of the data period and contract period trends multiplied by (1 + IBNR factor)

The resulting trend factors are shown in Exhibit II.3. These trend and IBNR factors are applied to the historical data in Exhibit II.4 by applicable service category.

II.E Capitation Rates for FAMIS MOMS

The historical data presented in Exhibit II.1 is adjusted by the factors shown in Exhibits II.2a through II.2h and the Trend and IBNR factors in Exhibit II.3. The result of these calculations is shown in Exhibit II.4.

FY 2008 FAMIS MOMS base rate is presented in Exhibit II.5a. Unlike the FAMIS program, there is no adjustment for co-payments. The comparison of FAMIS MOMS rates from FY2009 and FY2010 is shown in Exhibit II.5b and is a reduction of 12.63%.

III. Summary of FY 2009 and FY 2010 Capitation Rates

The budget passed by the state legislature limited the Medallion II and FAMIS program rate increases. The DMAS policy interpretation is to apply the cap to FAMIS and FAMIS MOMS in the aggregate rather than as separate programs. .

As a stand-alone program, the effect of the budget cap adjusted for the hospital inpatient payment reductions is to limit the FY 2010 FAMIS rates to a 6.28% increase. This is shown in Exhibit I.2g. In contrast, FAMIS MOMS rates are subject to the hospital fee reductions but FY 2010 rates are 12.63% less than the FY 2009 rates and are not subject to the budget cap.

Exhibit III.1a presents the weighted average of the FAMIS and FAMIS MOMS rate development. After adjustment for the hospital fee reductions and the state budget cap, the FAMIS plus FAMIS MOMS PMPM is a weighted average of \$127.27. This is a weighted average increase of 6.17% across the two programs. Keeping the FAMIS MOMS FY 2010 rates at \$820.14 PMPM, the FAMIS state budget cap factor is reduced from a negative 16.1% (Exhibit I.2k and Exhibit I.5a) to a negative 13.44%. This difference is a \$3.47 PMPM increase to the weighted average FAMIS rate, from \$109.73 to \$113.20 PMPM, an overall increase of 9.64% compared to FY 2009.

Exhibit III.1b presents FY 2010 FAMIS rates using the negative 13.44% budget adjustment factor. Exhibit III.1c shows the comparison of FY 2009 and FY 2010 FAMIS rates.

All weighted average rates use health plan member months as of February 2009.

**Virginia Medicaid
FY 2010 Capitation Rate Development
Health Plan Encounter Data**

**Section I
Exhibit 1**

Historical Eligibility, Claims, and Utilization Data - Family Access to Medical Insurance Security (FAMIS)

Age Under 1												
Statewide	Raw Claims FY07	Raw Claims FY08	Capitation FY07	Capitation FY08	Unadjusted PMPM 07	Unadjusted PMPM 08	Units FY07	Units FY08	Units/1000 FY07	Units/1000 FY08	Cost/Unit FY07	Cost/Unit FY08
Member Months	12,204	14,635										
Service Type												
DME/Supplies	\$38,449	\$41,625	\$0	\$0	\$3.15	\$2.84	308	518	303	425	\$124.83	\$80.36
FQHC / RHC	\$5,202	\$7,676	\$0	\$0	\$0.43	\$0.52	155	238	152	195	\$33.56	\$32.25
Home Health	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Newborn	\$492,159	\$305,284	\$0	\$0	\$40.33	\$20.86	62	54	61	44	\$7,938.05	\$5,653.40
IP - Other	\$355,247	\$309,560	\$0	\$0	\$29.11	\$21.15	82	87	81	71	\$4,332.28	\$3,558.16
IP - Psych	\$0	\$0	\$2,453	\$3,008	\$0.20	\$0.21	0	0	-	-	-	-
Lab	\$13,518	\$15,223	\$8,125	\$8,661	\$1.77	\$1.63	1,614	1,917	1,587	1,572	\$13.41	\$12.46
OP - Emergency Room	\$65,631	\$94,997	\$0	\$0	\$5.38	\$6.49	444	576	437	472	\$147.82	\$164.93
OP - Other	\$188,734	\$265,408	\$0	\$0	\$15.46	\$18.14	918	1,044	903	856	\$205.59	\$254.22
Pharmacy	\$178,725	\$283,586	\$0	\$0	\$14.64	\$19.38	4,809	5,310	4,729	4,354	\$37.16	\$53.41
Prof - Anesthesia	\$13,441	\$14,135	\$0	\$0	\$1.10	\$0.97	77	85	76	70	\$174.55	\$166.30
Prof - Child EPSDT	\$340,827	\$445,091	\$0	\$0	\$27.93	\$30.41	9,720	11,960	9,558	9,807	\$35.06	\$37.21
Prof - Evaluation & Management	\$646,421	\$836,256	\$14,155	\$20,621	\$54.13	\$58.55	11,587	13,369	11,393	10,962	\$57.01	\$64.09
Prof - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
Prof - Other	\$150,705	\$192,305	\$1,384	\$1,503	\$12.46	\$13.24	8,732	11,653	8,586	9,555	\$17.42	\$16.63
Prof - Psych	\$0	\$28	\$4,504	\$5,523	\$0.37	\$0.38	0	2	-	2	-	\$2,775.51
Prof - Specialist	\$41,415	\$54,575	\$0	\$0	\$3.39	\$3.73	404	531	397	435	\$102.51	\$102.78
Prof - Vision	\$3,945	\$4,067	\$10,689	\$11,350	\$1.20	\$1.05	95	97	93	80	\$154.04	\$158.94
Radiology	\$11,071	\$13,759	\$0	\$0	\$0.91	\$0.94	714	798	702	654	\$15.51	\$17.24
Transportation/Ambulance	\$16,567	\$5,139	\$0	\$0	\$1.36	\$0.35	38	25	37	20	\$435.97	\$205.57
Total	\$2,562,055	\$2,888,717	\$41,311	\$50,667	\$213.32	\$200.85	39,759	48,264				

Note:
*Plans may not provide complete unit counts for subcapitated encounters, thus Cost/Unit may not be accurate.

**Virginia Medicaid
FY 2010 Capitation Rate Development
Health Plan Encounter Data**

**Section I
Exhibit 1**

Historical Eligibility, Claims, and Utilization Data - Family Access to Medical Insurance Security (FAMIS)

Age 1-5												
Statewide	Raw Claims FY07	Raw Claims FY08	Capitation FY07	Capitation FY08	Unadjusted PMPM 07	Unadjusted PMPM 08	Units FY07	Units FY08	Units/1000 FY07	Units/1000 FY08	Cost/Unit FY07	Cost/Unit FY08
Member Months	150,544	171,907										
Service Type												
DME/Supplies	\$122,379	\$210,925	\$0	\$0	\$0.81	\$1.23	1,259	2,237	100	156	\$97.20	\$94.29
FQHC / RHC	\$46,478	\$42,735	\$0	\$0	\$0.31	\$0.25	1,745	1,567	139	109	\$26.63	\$27.27
Home Health	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Newborn	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Other	\$945,595	\$1,977,773	\$0	\$0	\$6.28	\$11.50	316	361	25	25	\$2,992.39	\$5,478.60
IP - Psych	\$0	\$16,351	\$34,597	\$39,700	\$0.23	\$0.33	0	26	-	2	-	\$2,155.82
Lab	\$177,953	\$214,359	\$111,568	\$107,755	\$1.92	\$1.87	22,398	25,463	1,785	1,777	\$12.93	\$12.65
OP - Emergency Room	\$588,765	\$771,140	\$0	\$0	\$3.91	\$4.49	3,739	4,428	298	309	\$157.47	\$174.15
OP - Other	\$2,191,082	\$2,804,505	\$0	\$0	\$14.55	\$16.31	6,700	8,678	534	606	\$327.03	\$323.17
Pharmacy	\$2,039,011	\$2,459,182	\$0	\$0	\$13.54	\$14.31	48,206	55,211	3,843	3,854	\$42.30	\$44.54
Prof - Anesthesia	\$124,017	\$215,866	\$0	\$0	\$0.82	\$1.26	862	1,061	69	74	\$143.87	\$203.45
Prof - Child EPSDT	\$622,769	\$903,378	\$0	\$0	\$4.14	\$5.26	25,337	29,623	2,020	2,068	\$24.58	\$30.50
Prof - Evaluation & Management	\$3,201,412	\$4,445,801	\$181,107	\$236,509	\$22.47	\$27.24	63,805	76,230	5,086	5,321	\$53.01	\$61.42
Prof - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
Prof - Other	\$867,723	\$948,727	\$20,270	\$19,933	\$5.90	\$5.63	55,965	66,498	4,461	4,642	\$15.87	\$14.57
Prof - Psych	\$30,692	\$41,002	\$63,524	\$72,895	\$0.63	\$0.66	889	1,063	71	74	\$105.98	\$107.15
Prof - Specialist	\$378,708	\$495,685	\$0	\$0	\$2.52	\$2.88	4,151	5,022	331	351	\$91.23	\$98.70
Prof - Vision	\$31,624	\$44,168	\$130,778	\$138,034	\$1.08	\$1.06	897	1,254	72	88	\$181.05	\$145.30
Radiology	\$70,606	\$197,277	\$0	\$0	\$0.47	\$1.15	4,319	5,514	344	385	\$16.35	\$35.78
Transportation/Ambulance	\$62,354	\$48,761	\$0	\$0	\$0.41	\$0.28	235	277	19	19	\$265.34	\$176.03
Total	\$11,501,168	\$15,837,635	\$541,844	\$614,826	\$80.00	\$95.71	240,823	284,513				

Note:
*Plans may not provide complete unit counts for subcapitated encounters, thus Cost/Unit may not be accurate.

**Virginia Medicaid
FY 2010 Capitation Rate Development
Health Plan Encounter Data**

**Section I
Exhibit 1**

Historical Eligibility, Claims, and Utilization Data - Family Access to Medical Insurance Security (FAMIS)

Age 6-14												
Statewide	Raw Claims FY07	Raw Claims FY08	Capitation FY07	Capitation FY08	Unadjusted PMPM 07	Unadjusted PMPM 08	Units FY07	Units FY08	Units/1000 FY07	Units/1000 FY08	Cost/Unit FY07	Cost/Unit FY08
Member Months	211,620	237,434										
Service Type												
DME/Supplies	\$250,948	\$209,105	\$0	\$0	\$1.19	\$0.88	1,572	1,821	89	92	\$159.64	\$114.83
FQHC / RHC	\$49,338	\$58,577	\$0	\$0	\$0.23	\$0.25	1,865	1,756	106	89	\$26.45	\$33.36
Home Health	\$93	\$0	\$0	\$0	\$0.00	\$0.00	1	0	0	-	\$92.50	-
IP - Maternity	\$6,616	\$5,948	\$0	\$0	\$0.03	\$0.03	2	2	0	0	\$3,308.11	\$2,974.02
IP - Newborn	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Other	\$1,591,010	\$2,331,931	\$0	\$0	\$7.52	\$9.82	233	279	13	14	\$6,828.37	\$8,358.17
IP - Psych	\$90,828	\$100,079	\$41,182	\$50,820	\$0.62	\$0.64	251	332	14	17	\$525.93	\$454.52
Lab	\$205,829	\$239,504	\$162,480	\$154,421	\$1.74	\$1.66	22,578	26,339	1,280	1,331	\$16.31	\$14.96
OP - Emergency Room	\$515,475	\$674,831	\$0	\$0	\$2.44	\$2.84	2,869	3,079	163	156	\$179.67	\$219.17
OP - Other	\$2,449,519	\$2,804,233	\$0	\$0	\$11.58	\$11.81	6,859	8,659	389	438	\$357.12	\$323.85
Pharmacy	\$4,254,559	\$5,421,515	\$0	\$0	\$20.10	\$22.83	65,569	75,523	3,718	3,817	\$64.89	\$71.79
Prof - Anesthesia	\$100,707	\$114,883	\$0	\$0	\$0.48	\$0.48	635	700	36	35	\$158.59	\$164.12
Prof - Child EPSDT	\$154,118	\$283,081	\$0	\$0	\$0.73	\$1.19	17,325	18,245	982	922	\$8.90	\$15.52
Prof - Evaluation & Management	\$2,597,314	\$3,556,662	\$245,614	\$312,878	\$13.43	\$16.30	50,630	59,652	2,871	3,015	\$56.15	\$64.87
Prof - Maternity	\$3,596	\$4,125	\$0	\$0	\$0.02	\$0.02	2	4	0	0	\$1,797.82	\$1,031.26
Prof - Other	\$791,660	\$1,474,202	\$29,614	\$28,106	\$3.88	\$6.33	60,099	97,597	3,408	4,933	\$13.67	\$15.39
Prof - Psych	\$314,494	\$344,862	\$101,293	\$120,444	\$1.96	\$1.96	8,119	9,214	460	466	\$51.21	\$50.50
Prof - Specialist	\$418,363	\$507,260	\$0	\$0	\$1.98	\$2.14	4,144	4,787	235	242	\$100.96	\$105.97
Prof - Vision	\$54,233	\$74,587	\$183,916	\$195,046	\$1.13	\$1.14	4,397	5,769	249	292	\$54.16	\$46.74
Radiology	\$129,083	\$167,045	\$0	\$0	\$0.61	\$0.70	6,626	7,711	376	390	\$19.48	\$21.66
Transportation/Ambulance	\$41,295	\$54,466	\$0	\$0	\$0.20	\$0.23	185	244	10	12	\$223.22	\$223.22
Total	\$14,019,077	\$18,426,895	\$764,099	\$861,715	\$69.86	\$81.24	253,961	321,713				

Note:

*Plans may not provide complete unit counts for subcapitated encounters, thus Cost/Unit may not be accurate.

**Virginia Medicaid
FY 2010 Capitation Rate Development
Health Plan Encounter Data**

**Section I
Exhibit 1**

Historical Eligibility, Claims, and Utilization Data - Family Access to Medical Insurance Security (FAMIS)

Age 15-18 Female												
Statewide	Raw Claims FY07	Raw Claims FY08	Capitation FY07	Capitation FY08	Unadjusted PMPM 07	Unadjusted PMPM 08	Units FY07	Units FY08	Units/1000 FY07	Units/1000 FY08	Cost/Unit FY07	Cost/Unit FY08
Member Months	37,645	42,729										
Service Type												
DME/Supplies	\$36,568	\$41,490	\$0	\$0	\$0.97	\$0.97	280	256	89	72	\$130.60	\$162.07
FQHC / RHC	\$26,747	\$24,301	\$0	\$0	\$0.71	\$0.57	887	824	283	231	\$30.15	\$29.49
Home Health	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Maternity	\$427,413	\$374,084	\$0	\$0	\$11.35	\$8.75	147	138	47	39	\$2,907.57	\$2,710.76
IP - Newborn	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Other	\$380,600	\$476,938	\$0	\$0	\$10.11	\$11.16	62	71	20	20	\$6,138.72	\$6,717.44
IP - Psych	\$66,344	\$236,064	\$6,591	\$11,240	\$1.94	\$5.79	197	345	63	97	\$370.23	\$716.82
Lab	\$80,109	\$111,832	\$29,259	\$28,087	\$2.91	\$3.27	9,746	12,108	3,107	3,400	\$11.22	\$11.56
OP - Emergency Room	\$201,656	\$247,562	\$0	\$0	\$5.36	\$5.79	842	971	268	273	\$239.50	\$254.96
OP - Other	\$857,139	\$1,021,935	\$0	\$0	\$22.77	\$23.92	2,422	2,701	772	759	\$353.90	\$378.35
Pharmacy	\$1,290,881	\$1,554,415	\$0	\$0	\$34.29	\$36.38	16,265	18,568	5,185	5,215	\$79.37	\$83.71
Prof - Anesthesia	\$59,849	\$64,206	\$0	\$0	\$1.59	\$1.50	270	315	86	88	\$221.66	\$203.83
Prof - Child EPSDT	\$29,033	\$35,367	\$0	\$0	\$0.77	\$0.83	1,365	2,472	435	694	\$21.27	\$14.31
Prof - Evaluation & Management	\$610,900	\$791,981	\$42,428	\$52,852	\$17.35	\$19.77	11,626	13,179	3,706	3,701	\$56.20	\$64.10
Prof - Maternity	\$217,714	\$215,853	\$0	\$0	\$5.78	\$5.05	465	446	148	125	\$468.20	\$483.98
Prof - Other	\$171,453	\$322,167	\$5,270	\$5,144	\$4.69	\$7.66	8,294	11,515	2,644	3,234	\$21.31	\$28.42
Prof - Psych	\$68,813	\$92,487	\$19,327	\$23,713	\$2.34	\$2.72	1,873	2,119	597	595	\$47.06	\$54.84
Prof - Specialist	\$120,829	\$152,321	\$0	\$0	\$3.21	\$3.56	1,377	1,898	439	533	\$87.75	\$80.25
Prof - Vision	\$9,336	\$11,401	\$32,759	\$35,547	\$1.12	\$1.10	950	1,408	303	395	\$44.31	\$33.34
Radiology	\$98,301	\$123,377	\$0	\$0	\$2.61	\$2.89	2,556	2,908	815	817	\$38.46	\$42.43
Transportation/Ambulance	\$20,646	\$16,345	\$0	\$0	\$0.55	\$0.38	127	110	40	31	\$162.56	\$148.59
Total	\$4,774,332	\$5,914,128	\$135,634	\$156,584	\$130.43	\$142.07	59,751	72,352				

Note:
*Plans may not provide complete unit counts for subcapitated encounters, thus Cost/Unit may not be accurate.

**Virginia Medicaid
FY 2010 Capitation Rate Development
Health Plan Encounter Data**

**Section I
Exhibit 1**

Historical Eligibility, Claims, and Utilization Data - Family Access to Medical Insurance Security (FAMIS)

Age 15-18 Male												
Statewide	Raw Claims FY07	Raw Claims FY08	Capitation FY07	Capitation FY08	Unadjusted PMPM 07	Unadjusted PMPM 08	Units FY07	Units FY08	Units/1000 FY07	Units/1000 FY08	Cost/Unit FY07	Cost/Unit FY08
Member Months	36,002	41,045										
Service Type												
DME/Supplies	\$36,552	\$57,960	\$0	\$0	\$1.02	\$1.41	342	323	114	94	\$106.88	\$179.44
FQHC / RHC	\$9,730	\$9,772	\$0	\$0	\$0.27	\$0.24	294	314	98	92	\$33.10	\$31.12
Home Health	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Newborn	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Other	\$631,220	\$751,515	\$0	\$0	\$17.53	\$18.31	72	62	24	18	\$8,766.94	\$12,121.21
IP - Psych	\$23,310	\$78,037	\$8,720	\$10,272	\$0.89	\$2.15	45	147	15	43	\$711.78	\$600.74
Lab	\$29,941	\$35,635	\$27,985	\$26,821	\$1.61	\$1.52	3,579	3,786	1,193	1,107	\$16.19	\$16.50
OP - Emergency Room	\$126,337	\$175,419	\$0	\$0	\$3.51	\$4.27	553	614	184	180	\$228.46	\$285.70
OP - Other	\$944,807	\$976,332	\$0	\$0	\$26.24	\$23.79	1,540	1,733	513	507	\$613.51	\$563.38
Pharmacy	\$847,525	\$939,330	\$0	\$0	\$23.54	\$22.89	10,173	11,352	3,391	3,319	\$83.31	\$82.75
Prof - Anesthesia	\$26,506	\$23,670	\$0	\$0	\$0.74	\$0.58	138	139	46	41	\$192.07	\$170.29
Prof - Child EPSDT	\$13,950	\$20,108	\$0	\$0	\$0.39	\$0.49	790	1,057	263	309	\$17.66	\$19.02
Prof - Evaluation & Management	\$386,012	\$494,495	\$40,200	\$52,024	\$11.84	\$13.32	7,130	7,980	2,377	2,333	\$59.78	\$68.49
Prof - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
Prof - Other	\$116,059	\$153,110	\$5,128	\$4,950	\$3.37	\$3.85	6,037	8,755	2,012	2,560	\$20.07	\$18.05
Prof - Psych	\$69,033	\$75,513	\$18,449	\$22,266	\$2.43	\$2.38	1,808	1,898	603	555	\$48.39	\$51.52
Prof - Specialist	\$136,140	\$143,152	\$0	\$0	\$3.78	\$3.49	1,070	1,121	357	328	\$127.23	\$127.70
Prof - Vision	\$7,205	\$9,552	\$31,368	\$33,895	\$1.07	\$1.06	640	947	213	277	\$60.27	\$45.88
Radiology	\$58,822	\$53,197	\$0	\$0	\$1.63	\$1.30	1,978	2,138	659	625	\$29.74	\$24.88
Transportation/Ambulance	\$15,229	\$27,998	\$0	\$0	\$0.42	\$0.68	85	194	28	57	\$179.17	\$144.32
Total	\$3,478,379	\$4,024,797	\$131,850	\$150,228	\$100.28	\$101.72	36,274	42,560				

Note:
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**Virginia Medicaid
FY 2010 Capitation Rate Development
Health Plan Encounter Data**

**Section I
Exhibit 1**

Historical Eligibility, Claims, and Utilization Data - Family Access to Medical Insurance Security (FAMIS)

All Age Categories												
Statewide	Raw Claims FY07	Raw Claims FY08	Capitation FY07	Capitation FY08	Unadjusted PMPM 07	Unadjusted PMPM 08	Units FY07	Units FY08	Units/1000 FY07	Units/1000 FY08	Cost/Unit FY07	Cost/Unit FY08
Member Months	448,015	507,750										
Service Type												
DME/Supplies	\$484,897	\$561,105	\$0	\$0	\$1.08	\$1.11	3,761	5,155	101	122	\$128.93	\$108.85
FQHC / RHC	\$137,495	\$143,062	\$0	\$0	\$0.31	\$0.28	4,946	4,699	132	111	\$27.80	\$30.45
Home Health	\$93	\$0	\$0	\$0	\$0.00	\$0.00	1	0	0	-	\$92.50	-
IP - Maternity	\$434,029	\$380,032	\$0	\$0	\$0.97	\$0.75	149	140	4	3	\$2,912.95	\$2,714.52
IP - Newborn	\$492,159	\$305,284	\$0	\$0	\$1.10	\$0.60	62	54	2	1	\$7,938.05	\$5,653.40
IP - Other	\$3,903,671	\$5,847,716	\$0	\$0	\$8.71	\$11.52	765	860	20	20	\$5,102.84	\$6,799.67
IP - Psych	\$254,489	\$508,898	\$112,790	\$133,346	\$0.82	\$1.26	493	850	13	20	\$744.99	\$755.58
Lab	\$507,350	\$616,554	\$339,418	\$325,746	\$1.89	\$1.86	59,915	69,613	1,605	1,645	\$14.13	\$13.54
OP - Emergency Room	\$1,497,864	\$1,963,950	\$0	\$0	\$3.34	\$3.87	8,447	9,668	226	228	\$177.32	\$203.14
OP - Other	\$6,631,281	\$7,872,412	\$0	\$0	\$14.80	\$15.50	18,439	22,815	494	539	\$359.63	\$345.05
Pharmacy	\$8,610,700	\$10,658,028	\$0	\$0	\$19.22	\$20.99	145,022	165,964	3,884	3,922	\$59.38	\$64.22
Prof - Anesthesia	\$324,520	\$432,761	\$0	\$0	\$0.72	\$0.85	1,982	2,300	53	54	\$163.73	\$188.16
Prof - Child EPSDT	\$1,160,698	\$1,687,026	\$0	\$0	\$2.59	\$3.32	54,537	63,357	1,461	1,497	\$21.28	\$26.63
Prof - Evaluation & Management	\$7,442,058	\$10,125,195	\$523,505	\$674,885	\$17.78	\$21.27	144,778	170,410	3,878	4,027	\$55.02	\$63.38
Prof - Maternity	\$221,309	\$219,978	\$0	\$0	\$0.49	\$0.43	467	450	13	11	\$473.90	\$488.84
Prof - Other	\$2,097,600	\$3,090,512	\$61,666	\$59,637	\$4.82	\$6.20	139,127	196,018	3,726	4,633	\$15.52	\$16.07
Prof - Psych	\$483,032	\$553,892	\$207,097	\$244,840	\$1.54	\$1.57	12,689	14,296	340	338	\$54.39	\$55.87
Prof - Specialist	\$1,095,455	\$1,352,993	\$0	\$0	\$2.45	\$2.66	11,146	13,359	299	316	\$98.28	\$101.28
Prof - Vision	\$106,343	\$143,776	\$389,510	\$413,872	\$1.11	\$1.10	6,979	9,475	187	224	\$71.05	\$58.85
Radiology	\$367,884	\$554,655	\$0	\$0	\$0.82	\$1.09	16,193	19,069	434	451	\$22.72	\$29.09
Transportation/Ambulance	\$156,090	\$152,709	\$0	\$0	\$0.35	\$0.30	670	850	18	20	\$232.97	\$179.66
Total	\$36,409,018	\$47,170,539	\$1,633,986	\$1,852,326	\$84.91	\$96.55	630,568	769,402				

Note:
*Plans may not provide complete unit counts for subcapitated encounters, thus Cost/Unit may not be accurate.

**Virginia Medicaid
 FY 2010 FAMIS Capitation Rate Development
 Health Plan Encounter Data
 Pharmacy Adjustment**

**Section I
 Exhibit 2a**

	FAMIS All Ages	Source
1. Health Plan Total Drug Cost PMPM	\$20.16	FY07-FY08 Health Plan Encounter Data
2. Average Managed Care Rebate	3.6%	From Plan Data
3. Adjusted PMPM with Managed Care Rebate	\$19.43	= (1.) * (1 - (2.))
4. Average PBM Admin Cost PMPM	\$0.04	From Plan Data
5. Adjusted PMPM with Pharmacy Pricing Arrangements	\$19.47	= (3.) + (4.)
6. Pharmacy Adjustment	-3.4%	= (5.) / (1.) - 1

Virginia Medicaid
FY 2010 FAMIS Capitation Rate Development
Health Plan Encounter Data
Pediatric E&M Fee Increase Adjustment

Section I
Exhibit 2b

		FAMIS All Ages	Source
1. Claims Associated with Pediatric E&M Procedure Codes	a. FQHC / RHC	\$84,250	FY07 Health Plan Encounter Data
	b. Prof - Evaluation & Management	\$6,862,650	
2. % Fee Increase Effective FY08		10%	Provided by DMAS
3. Dollar Increase	a. FQHC / RHC	\$8,425	= (1.) * (2.)
	b. Prof - Evaluation & Management	\$686,265	
4. Total claims in Service Category	a. FQHC / RHC	\$280,556	FY07-FY08 Health Plan Encounter Data
	b. Prof - Evaluation & Management	\$18,765,643	
5. Pediatric E&M Fee Increase Adjustment	a. FQHC / RHC	3.0%	= (3.) / (4.)
	b. Prof - Evaluation & Management	3.7%	

Virginia Medicaid
FY 2010 FAMIS Capitation Rate Development
Health Plan Encounter Data
Professional Fee Increase Adjustment (Excluding Pediatric E&M and OB-GYN services)

Section I
Exhibit 2c

		FAMIS All Ages	Source
1. Claims Associated with Professional Services*	a. Prof - Evaluation & Management	\$1,195,672	FY07 Health Plan Encounter Data
	b. Prof - Specialist	\$1,074,473	
	c. All Other Professional Categories	\$4,834,061	
2. % Fee Increase Effective FY08		5%	Provided by DMAS
3. Dollar Increase	a. Prof - Evaluation & Management	\$59,784	= (1.) * (2.)
	b. Prof - Specialist	\$53,724	
	c. All Other Professional Categories	\$241,703	
4. Total claims in Service Category	a. Prof - Evaluation & Management	\$18,765,643	FY07-FY08 Health Plan Encounter Data
	b. Prof - Specialist	\$2,448,449	
	c. All Other Professional Categories	\$11,898,068	
5. Professional Fee Increase Adjustment	a. Prof - Evaluation & Management	0.3%	= (3.) / (4.)
	b. Prof - Specialist	2.2%	
	c. All Other Professional Categories	2.0%	

* Note:

Claims associated with OB-GYN and Pediatric E&M procedure codes have been excluded from this adjustment.

Virginia Medicaid
FY 2010 FAMIS Capitation Rate Development
Health Plan Encounter Data
Exempt Infant Formula Carveout Adjustment

Section I
Exhibit 2d

	FAMIS Age 0-5	FAMIS Age 6-18	Source
1. Claims Associated with Exempt Infant Formula	\$21,453	\$28,108	FY07-FY08 Health Plan Encounter Data
2. Total Claims in DME/Supplies Service Category	\$413,379	\$632,624	FY07-FY08 Health Plan Encounter Data
3. Exempt Infant Formula Carveout Adjustment	-5.2%	-4.4%	= -(1.) / (2.)

**Virginia Medicaid
 FY 2010 FAMIS Capitation Rate Development
 Health Plan Encounter Data
 Other Immunization Adjustments**

**Section I
 Exhibit 2e**

	FAMIS Age Under 1	FAMIS Age 1-5	FAMIS Age 6-14	Source
1. Average Members in Rate Cell	1,118	13,435	18,711	Estimated from capitation payment files
2. Assumed Compliance Rate	68.0%	68.0%	34.5%	Provided by DMAS
3. Assumed Penetration	71.4%	35.6%	65.3%	Provided by DMAS
4. Estimated Administration Cost	\$44.00	\$33.00	\$22.00	Provided by DMAS
5. Estimated Serum Cost	\$223.70	\$176.09	\$80.58	Provided by DMAS
6. Total Dollar Increase	\$145,283	\$679,686	\$432,066	= (1.) * (2.) * (3.) * ((4.) + (5.))
7. Proportion of Claims to be Adjusted	21%	21%	21%	
8. Total Claims in Prof - Evaluation & Management Service Category	\$1,517,453	\$8,064,829	\$6,712,468	FY07-FY08 Health Plan Encounter Data
9. Other Immunization Adjustments	2.0%	1.8%	1.3%	= (6.) * (7.) / (8.)

Notes (Included Vaccines):

Rotavirus vaccine - 3 Doses (age under 1); effective December 1, 2006

Influenza vaccine (age 6-59 months); effective December 1, 2006

Varicella vaccine (recommended second dose at age 4-6); effective December 1, 2006

**Virginia Medicaid
 FY 2010 FAMIS Capitation Rate Development
 Health Plan Encounter Data
 HPV Vaccine Adjustment**

**Section I
 Exhibit 2f**

	FAMIS Age 6-18 Female	Source
1. Average Members in Rate Cell	22,060	Estimated from capitation payment files
2. Assumed Penetration*	5.7%	
3. Estimated Administration Cost	\$33.00	Provided by DMAS
4. Estimated Serum Cost	\$390.81	Provided by DMAS
5. Total Dollar Increase	\$534,039	= (1.) * (2.) * ((3.) + (4.))
6. Proportion of Claims to be Adjusted	21%	
7. Total Claims in Prof - Evaluation & Management Service Category	\$8,210,630	FY07-FY08 Health Plan Encounter Data
8. HPV Vaccine Adjustment	1.4%	= (5.) * (6.) / (7.)

*Note:

Assumed penetration is 10% adjusted for the proportion of females in the rate cell who will receive the HPV vaccine.

**Virginia Medicaid
 FY 2010 FAMIS Capitation Rate Development
 Health Plan Encounter Data
 Hospital Inpatient Adjustments**

**Section I
 Exhibit 2g**

	Inpatient Medical/Surgical	Inpatient Psychiatric	Source
1. FY07 Hospital Inpatient Operating Adjustment Factor	78.0%	78.0%	Provided by DMAS
FY08 Hospital Inpatient Operating Adjustment Factor	78.0%	84.0%	
2. FY07 Inpatient Claims	\$4,829,860	\$254,489	FY07-FY08 Health Plan Encounter Data
FY08 Inpatient Claims	\$6,533,032	\$508,898	
3. FY07-FY08 Hospital Inpatient Operating Adjustment Factor	78.0%	82.0%	Weighted Average of FY07 - FY08
4. FY09 Hospital Inpatient Operating Adjustment Factor	78.0%	84.0%	Provided by DMAS
5. FY09 Hospital Rate Reduction	2.7%	2.7%	Provided by DMAS
6. FY10 Hospital Rate Reduction	4.0%	4.0%	Provided by DMAS
7. FY09 Hospital Capital Percentage	10.0%	10.0%	Provided by DMAS
8. FY10 Capital Reimbursement Reduction for Private Hospitals	6.3%	6.3%	Provided by DMAS
9. % Excluded Claims from Exempt Hospitals*	25.6%	12.7%	FY07-FY08 Health Plan Encounter Data
10. Hospital Inpatient Adjustment	-6.4%	-4.4%	$= (((4.) * (1 - (5.)) * (1 - (6.))) / (3.)) * (1 - (7.))$ $+ ((7.) * (1 - (9.)) * (1 - (8.)) + (7.) * (9.) - 1)$

*Exempt hospitals are CHKD, UVA, and MCV.

Virginia Medicaid
FY 2010 FAMIS Capitation Rate Development
Health Plan Encounter Data
Rural Wage Index Adjustment

Section I
Exhibit 2h

	FAMIS All Ages	Source
1. Estimated Impact of Adjustment	\$536,604	Provided by DMAS
2. Total Claims in IP - Other Service Category	\$332,442,606	FY07-FY08 Medallion II Health Plan Encounter Data
3. Proportion of Claims to be Adjusted	47%	FY07 Medallion II Health Plan Encounter Data
4. Rural Wage Index Adjustment	0.1%	= (1.) / (2.) * (3.)

Virginia Medicaid
FY 2010 FAMIS Capitation Rate Development
Health Plan Encounter Data
Provider Incentive Payment Adjustment

Section I
Exhibit 2i

	Adjustment Value	Source
Provider Incentive Payment Adjustment	2.9%	From Plan Data

**Virginia Medicaid
 FY 2010 FAMIS Capitation Rate Development
 Health Plan Encounter Data
 Administrative Cost Adjustment**

**Section I
 Exhibit 2j**

	FAMIS	Source
1. Claims Adjustment Expense PMPM	\$1.25	Expense from CY2008 BOI Reports; Member months from capitation payment files
2. General Admin Expense PMPM	\$7.30	Expense from CY2008 BOI Reports; Member months from capitation payment files
3. Claims Adjustment Expense Increase %	1.8%	BLS CPI-U
4. General Admin Expense Increase %	2.7%	Weighted average of BLS Compensation Trend and CPI
5. Administrative PMPM*	\$8.88	= (1.) * (1+ (3.)) ^ (18 months/12) + (2.) * (1+ (4.)) ^ (18 months/12)
6. Adjusted and Trended Base PMPM	\$125.98	Weighted average of medical component of FY2010 MedII Base Rates
7. Administrative allowance as % of Base Capitation Rate	6.54%	= (5.) / (((5.) + (6.)) / (1 - 0.75%))
8. Contribution to Reserves as % of Base Capitation Rate	0.75%	Provided by DMAS
9. Administrative Factor as % of Base Capitation Rate	7.29%	= (7.) + (8.)

*Note:

Administrative increases are applied from midpoint of CY2008 to the midpoint of the contract period (18 months) using compound interest calculations.

**Virginia Medicaid
 FY 2010 FAMIS Capitation Rate Development
 Health Plan Encounter Data
 State Budget Cap Adjustment**

**Section I
 Exhibit 2k**

	PMPM	% Change	Source
1. FY 2009 Average Rate Weighted by Feb 2009 MM	\$103.25		FAMIS FY2009 Rates
2. FY 2010 Average Rate before FFS Payment Adjustments and State Budget Cap	\$131.52	27.38%	= (2.) / (1.) - (1.)
3. FY 2010 Average Rate with FFS Payment Adjustments Only	\$130.77	26.66%	= (3.) / (1.) - (1.)
4. FFS Payment Adjustment Effect	\$0.75	0.72%	= (2.) - (3.)
5. State Budget Cap*	\$110.48	7%	% Provided by DMAS; PMPM calculated as (1.) * (1 + 7%)
6. FY 2010 Average Rate Weighted by Feb 2009 MM	\$109.73	6.28%	= (5.) - (4.)
7. State Budget Cap Adjustment Factor		-16.1%	= (6.) / (3.) - 1

*FY 2010 state budget is capped at 7% increase less the value of FFS payment adjustments.

Virginia Medicaid
FY 2010 FAMIS Capitation Rate Development
Health Plan Encounter Data
Trend and Incurred But Not Reported (IBNR) Adjustments - FAMIS

Section I
Exhibit 3

Category of Service	FAMIS							
	Completion and Policy/Program Adjustments			Data Period Trend			Contract Period Cost and Utilization Trend	Total Trend Factor
	IBNR	Policy/Program ¹	Total Base Data Adjustments	Cost Trend	Utilization Trend	Cost and Utilization Trend		
Inpatient Medical/Surgical	0.3%	-6.3%	-6.1%	13.7%	-3.2%	10.1%	8.4%	1.2423
Inpatient Psychiatric	0.0%	-4.4%	-4.4%	18.6%	81.9%	115.6%	39.9%	3.5663
Outpatient Hospital	0.5%	0.0%	0.5%	0.0%	7.1%	7.2%	7.3%	1.1917
Practitioner	0.4%	4.0%	4.4%	6.3%	5.8%	12.4%	14.1%	1.3695
Prescription Drug	0.0%	-3.4%	-3.4%	8.5%	2.0%	10.7%	8.5%	1.2505
Other	0.3%	0.0%	0.3%	6.6%	7.8%	14.9%	9.9%	1.3235
Weighted Average*	0.3%	0.1%	-0.5%	6.5%	4.9%	11.7%	10.9%	1.3096

Months of Trend Applied	12	12	12	18
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¹ The Policy and Program Adjustments are summarized in this table as weighted averages and are applied at the rate cell level in Exhibit 4.

² Weighted averages for Completion and Program Adjustments are calculated using a distribution by Service Type, before Trend and Adjustments (Total Claims FY07-FY08), whereas weighted averages for Trends are calculated using a distribution by Service Type, before Trend (Adjusted FY07-FY08 Claims)

Trend rates for managed care plans are calculated based on regression studies of historical health plan data.

Trend rates have been calculated separately for the broad service categories shown above. Utilization trend is based on service units per thousand.

Inpatient contract period trend included consideration of cost per unit projections provided by DMAS.

Data period trends are applied from the midpoint of the data period to the end of the data period using compound interest calculations. Contract period trends are applied from the end of the data period to the midpoint of the contract period using compound interest calculations.

Total Trend = [(1 + data period trend) ^ (months/12) * (1 + contract period trend) ^ (months/12)]

Virginia Medicaid
FY 2010 Capitation Rate Development
Capitation Rate Calculations - Health Plan Encounter Data
Family Access to Medical Insurance Security (FAMIS)

Section I
Exhibit 4

Age Under 1								
Statewide	Total Claims FY07 - FY08	Completion Factor Adjustment	Policy and Program Adjustments	Patient Copay	Completed and Adjusted Claims FY07 - FY08	Trend Adjustment FY07 - FY08	Completed & Trended Claims FY10	PMPM FY10
Service Type								
DME/Supplies	\$80,075	\$341	(\$4,173)	\$0	\$76,242	1.369	\$104,411	\$3.89
FQHC / RHC	\$12,878	\$55	\$388	\$733	\$14,054	1.369	\$19,247	\$0.72
Home Health	\$0			\$0	\$0	1.192	\$0	\$0.00
IP - Maternity	\$0			\$0	\$0	1.242	\$0	\$0.00
IP - Newborn	\$797,443	\$2,160	(\$51,281)	\$2,428	\$750,749	1.242	\$932,664	\$34.75
IP - Other	\$664,807	\$1,800	(\$42,241)	\$3,895	\$628,261	1.242	\$780,496	\$29.08
IP - Psych	\$5,461		(\$243)	\$0	\$5,218	3.566	\$4,596	\$0.17
Lab	\$45,527	\$88		\$5,654	\$51,269	1.323	\$62,422	\$2.33
OP - Emergency Room	\$160,629	\$724		\$9,604	\$170,957	1.192	\$203,738	\$7.59
OP - Other	\$454,142	\$2,048		\$8,670	\$464,860	1.192	\$553,996	\$20.64
Pharmacy	\$462,310	\$0	(\$15,723)	\$42,161	\$488,749	1.251	\$611,189	\$22.77
Prof - Anesthesia	\$27,576	\$117	\$563	\$0	\$28,256	1.369	\$38,695	\$1.44
Prof - Child EPSDT	\$785,918	\$3,346	\$16,034	\$0	\$805,298	1.369	\$1,102,826	\$41.09
Prof - Evaluation & Management	\$1,517,453	\$6,313	\$90,972	\$75,603	\$1,690,341	1.369	\$2,302,011	\$85.77
Prof - Maternity	\$0			\$0	\$0	1.369	\$0	\$0.00
Prof - Other	\$345,897	\$1,460	\$7,056	\$15,842	\$370,256	1.369	\$505,985	\$18.85
Prof - Psych	\$10,055	\$0	\$204	\$7	\$10,267	1.369	\$10,355	\$0.39
Prof - Specialist	\$95,990	\$409	\$2,115	\$1,982	\$100,496	1.369	\$137,626	\$5.13
Prof - Vision	\$30,052	\$34	\$611	\$380	\$31,077	1.369	\$34,416	\$1.28
Radiology	\$24,830	\$76		\$5,762	\$30,668	1.323	\$40,588	\$1.51
Transportation/Ambulance	\$21,706	\$66		\$179	\$21,951	1.323	\$29,052	\$1.08
Provider Incentive Payment Adjustment								\$8.12
Total	\$5,542,750	\$19,038	\$4,283	\$172,899	\$5,738,970		\$7,474,312	\$286.61

Virginia Medicaid
FY 2010 Capitation Rate Development
Capitation Rate Calculations - Health Plan Encounter Data
Family Access to Medical Insurance Security (FAMIS)

Section I
Exhibit 4

Age 1-5								
Statewide	Total Claims FY07 - FY08	Completion Factor Adjustment	Policy and Program Adjustments	Patient Copay	Completed and Adjusted Claims FY07 - FY08	Trend Adjustment FY07 - FY08	Completed & Trended Claims FY10	PMPM FY10
Service Type								
DME/Supplies	\$333,304	\$1,419	(\$17,371)	\$0	\$317,352	1.369	\$434,602	\$1.35
FQHC / RHC	\$89,212	\$380	\$2,690	\$6,475	\$98,758	1.369	\$135,245	\$0.42
Home Health	\$0			\$0	\$0	1.192	\$0	\$0.00
IP - Maternity	\$0			\$0	\$0	1.242	\$0	\$0.00
IP - Newborn	\$0			\$0	\$0	1.242	\$0	\$0.00
IP - Other	\$2,923,368	\$7,917	(\$185,748)	\$15,665	\$2,761,201	1.242	\$3,430,273	\$10.64
IP - Psych	\$90,648		(\$4,027)	\$75	\$86,695	3.566	\$118,513	\$0.37
Lab	\$611,636	\$1,196		\$82,888	\$695,720	1.323	\$849,817	\$2.64
OP - Emergency Room	\$1,359,905	\$6,133		\$75,975	\$1,442,013	1.192	\$1,718,517	\$5.33
OP - Other	\$4,995,587	\$22,529		\$70,673	\$5,088,788	1.192	\$6,064,556	\$18.81
Pharmacy	\$4,498,193	\$3	(\$152,981)	\$434,397	\$4,779,613	1.251	\$5,976,989	\$18.54
Prof - Anesthesia	\$339,883	\$1,447	\$6,934	\$0	\$348,264	1.369	\$476,935	\$1.48
Prof - Child EPSDT	\$1,526,148	\$6,498	\$31,135	\$0	\$1,563,781	1.369	\$2,141,539	\$6.64
Prof - Evaluation & Management	\$8,064,829	\$32,561	\$464,093	\$469,855	\$9,031,338	1.369	\$12,213,787	\$37.88
Prof - Maternity	\$0			\$0	\$0	1.369	\$0	\$0.00
Prof - Other	\$1,856,653	\$7,734	\$37,874	\$88,454	\$1,990,716	1.369	\$2,711,357	\$8.41
Prof - Psych	\$208,112	\$305	\$4,234	\$6,750	\$219,401	1.369	\$250,061	\$0.78
Prof - Specialist	\$874,392	\$3,723	\$19,268	\$24,014	\$921,397	1.369	\$1,261,819	\$3.91
Prof - Vision	\$344,605	\$323	\$7,007	\$5,702	\$357,636	1.369	\$390,453	\$1.21
Radiology	\$267,883	\$817		\$35,733	\$304,432	1.323	\$402,905	\$1.25
Transportation/Ambulance	\$111,115	\$339		\$1,397	\$112,851	1.323	\$149,355	\$0.46
Provider Incentive Payment Adjustment								\$3.50
Total	\$28,495,474	\$93,323	\$213,108	\$1,318,053	\$30,119,957		\$38,726,722	\$123.60

Virginia Medicaid
FY 2010 Capitation Rate Development
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Age 6-14								
Statewide	Total Claims FY07 - FY08	Completion Factor Adjustment	Policy and Program Adjustments	Patient Copay	Completed and Adjusted Claims FY07 - FY08	Trend Adjustment FY07 - FY08	Completed & Trended Claims FY10	PMPM FY10
Service Type								
DME/Supplies	\$460,053	\$1,959	(\$20,528)	\$0	\$441,484	1.369	\$604,596	\$1.35
FQHC / RHC	\$107,916	\$459	\$3,254	\$8,507	\$120,136	1.369	\$164,522	\$0.37
Home Health	\$93	\$0		\$5	\$98	1.192	\$117	\$0.00
IP - Maternity	\$12,564	\$34	(\$808)	\$80	\$11,870	1.242	\$14,747	\$0.03
IP - Newborn	\$0			\$0	\$0	1.242	\$0	\$0.00
IP - Other	\$3,922,940	\$10,624	(\$249,260)	\$11,845	\$3,696,149	1.242	\$4,591,769	\$10.23
IP - Psych	\$282,909		(\$12,570)	\$2,130	\$272,470	3.566	\$735,596	\$1.64
Lab	\$762,235	\$1,358		\$80,130	\$843,722	1.323	\$1,014,129	\$2.26
OP - Emergency Room	\$1,190,305	\$5,368		\$56,509	\$1,252,183	1.192	\$1,492,287	\$3.32
OP - Other	\$5,253,752	\$23,693		\$70,820	\$5,348,265	1.192	\$6,373,786	\$14.19
Pharmacy	\$9,676,074	\$7	(\$329,077)	\$582,744	\$9,929,748	1.251	\$12,417,322	\$27.65
Prof - Anesthesia	\$215,590	\$918	\$4,398	\$0	\$220,906	1.369	\$302,523	\$0.67
Prof - Child EPSDT	\$437,199	\$1,862	\$8,919	\$0	\$447,980	1.369	\$613,492	\$1.37
Prof - Evaluation & Management	\$6,712,468	\$26,203	\$449,581	\$368,794	\$7,557,045	1.369	\$10,142,749	\$22.59
Prof - Maternity	\$7,721	\$33		\$8	\$7,761	1.369	\$10,629	\$0.02
Prof - Other	\$2,323,582	\$9,648	\$47,398	\$92,138	\$2,472,766	1.369	\$3,365,035	\$7.49
Prof - Psych	\$881,092	\$2,807	\$17,956	\$67,049	\$968,905	1.369	\$1,244,956	\$2.77
Prof - Specialist	\$925,623	\$3,941	\$20,396	\$21,655	\$971,616	1.369	\$1,330,592	\$2.96
Prof - Vision	\$507,781	\$548	\$10,326	\$30,643	\$549,299	1.369	\$612,232	\$1.36
Radiology	\$296,128	\$903		\$48,177	\$345,208	1.323	\$456,870	\$1.02
Transportation/Ambulance	\$95,760	\$292		\$1,588	\$97,641	1.323	\$129,224	\$0.29
Provider Incentive Payment Adjustment								\$2.96
Total	\$34,071,786	\$90,657	(\$50,013)	\$1,442,822	\$35,555,252		\$45,617,175	\$104.55

Virginia Medicaid
FY 2010 Capitation Rate Development
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Family Access to Medical Insurance Security (FAMIS)

Section I
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Age 15-18 Female								
Statewide	Total Claims FY07 - FY08	Completion Factor Adjustment	Policy and Program Adjustments	Patient Copay	Completed and Adjusted Claims FY07 - FY08	Trend Adjustment FY07 - FY08	Completed & Trended Claims FY10	PMPM FY10
Service Type								
DME/Supplies	\$78,058	\$332	(\$3,483)	\$0	\$74,907	1.369	\$102,583	\$1.28
FQHC / RHC	\$51,048	\$217	\$1,539	\$3,539	\$56,344	1.369	\$77,160	\$0.96
Home Health	\$0			\$0	\$0	1.192	\$0	\$0.00
IP - Maternity	\$801,497	\$2,171	(\$51,542)	\$6,405	\$758,531	1.242	\$942,333	\$11.72
IP - Newborn	\$0			\$0	\$0	1.242	\$0	\$0.00
IP - Other	\$857,539	\$2,322	(\$54,487)	\$3,115	\$808,489	1.242	\$1,004,395	\$12.50
IP - Psych	\$320,238		(\$14,228)	\$1,920	\$307,930	3.566	\$1,052,399	\$13.09
Lab	\$249,288	\$585		\$39,083	\$288,956	1.323	\$363,874	\$4.53
OP - Emergency Room	\$449,218	\$2,026		\$16,787	\$468,031	1.192	\$557,775	\$6.94
OP - Other	\$1,879,074	\$8,474		\$24,251	\$1,911,799	1.192	\$2,278,384	\$28.35
Pharmacy	\$2,845,296	\$2	(\$96,767)	\$140,564	\$2,889,095	1.251	\$3,612,864	\$44.95
Prof - Anesthesia	\$124,055	\$528	\$2,531	\$0	\$127,114	1.369	\$174,078	\$2.17
Prof - Child EPSDT	\$64,400	\$274	\$1,314	\$0	\$65,988	1.369	\$90,368	\$1.12
Prof - Evaluation & Management	\$1,498,162	\$5,973	\$80,180	\$82,514	\$1,666,830	1.369	\$2,247,459	\$27.96
Prof - Maternity	\$433,567	\$1,846		\$1,103	\$436,516	1.369	\$597,792	\$7.44
Prof - Other	\$504,035	\$2,102	\$10,282	\$21,085	\$537,503	1.369	\$732,243	\$9.11
Prof - Psych	\$204,340	\$687	\$4,165	\$14,426	\$223,618	1.369	\$290,335	\$3.61
Prof - Specialist	\$273,150	\$1,163	\$6,019	\$7,026	\$287,358	1.369	\$393,527	\$4.90
Prof - Vision	\$89,044	\$88	\$1,811	\$6,471	\$97,414	1.369	\$108,168	\$1.35
Radiology	\$221,678	\$676		\$16,710	\$239,064	1.323	\$316,393	\$3.94
Transportation/Ambulance	\$36,991	\$113		\$565	\$37,669	1.323	\$49,853	\$0.62
Provider Incentive Payment Adjustment								\$5.44
Total	\$10,980,678	\$29,580	(\$112,665)	\$385,565	\$11,283,157		\$14,991,982	\$191.97

Virginia Medicaid
FY 2010 Capitation Rate Development
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Family Access to Medical Insurance Security (FAMIS)

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Age 15-18 Male								
Statewide	Total Claims FY07 - FY08	Completion Factor Adjustment	Policy and Program Adjustments	Patient Copay	Completed and Adjusted Claims FY07 - FY08	Trend Adjustment FY07 - FY08	Completed & Trended Claims FY10	PMPM FY10
Service Type								
DME/Supplies	\$94,512	\$402	(\$4,217)	\$0	\$90,698	1.369	\$124,207	\$1.61
FQHC / RHC	\$19,503	\$83	\$588	\$1,489	\$21,663	1.369	\$29,666	\$0.39
Home Health	\$0			\$0	\$0	1.192	\$0	\$0.00
IP - Maternity	\$0			\$0	\$0	1.242	\$0	\$0.00
IP - Newborn	\$0			\$0	\$0	1.242	\$0	\$0.00
IP - Other	\$1,382,734	\$3,745	(\$87,858)	\$3,040	\$1,301,661	1.242	\$1,617,069	\$20.99
IP - Psych	\$120,340		(\$5,347)	\$765	\$115,758	3.566	\$364,084	\$4.73
Lab	\$120,383	\$200		\$11,972	\$132,555	1.323	\$157,704	\$2.05
OP - Emergency Room	\$301,756	\$1,361		\$10,859	\$313,976	1.192	\$374,181	\$4.86
OP - Other	\$1,921,138	\$8,664		\$14,811	\$1,944,613	1.192	\$2,317,490	\$30.08
Pharmacy	\$1,786,856	\$1	(\$60,770)	\$85,366	\$1,811,453	1.251	\$2,265,254	\$29.40
Prof - Anesthesia	\$50,176	\$214	\$1,024	\$0	\$51,414	1.369	\$70,409	\$0.91
Prof - Child EPSDT	\$34,058	\$145	\$695	\$0	\$34,898	1.369	\$47,791	\$0.62
Prof - Evaluation & Management	\$972,730	\$3,749	\$38,821	\$51,961	\$1,067,262	1.369	\$1,427,502	\$18.53
Prof - Maternity	\$0			\$0	\$0	1.369	\$0	\$0.00
Prof - Other	\$279,248	\$1,146	\$5,696	\$13,293	\$299,383	1.369	\$406,270	\$5.27
Prof - Psych	\$185,261	\$615	\$3,776	\$13,009	\$202,662	1.369	\$262,495	\$3.41
Prof - Specialist	\$279,292	\$1,189	\$6,154	\$4,862	\$291,498	1.369	\$399,195	\$5.18
Prof - Vision	\$82,020	\$71	\$1,668	\$4,452	\$88,211	1.369	\$96,690	\$1.25
Radiology	\$112,019	\$341		\$13,459	\$125,819	1.323	\$166,517	\$2.16
Transportation/Ambulance	\$43,227	\$132		\$430	\$43,789	1.323	\$57,954	\$0.75
Provider Incentive Payment Adjustment								\$3.85
Total	\$7,785,254	\$22,059	(\$99,770)	\$229,769	\$7,937,312		\$10,184,477	\$136.04

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All Age Categories								
Statewide	Total Claims FY07 - FY08	Completion Factor Adjustment	Policy and Program Adjustments	Patient Copay	Completed and Adjusted Claims FY07 - FY08	Trend Adjustment FY07 - FY08	Completed & Trended Claims FY10	PMPM FY10
Service Type								
DME/Supplies	\$1,046,002	\$4,454	(\$49,773)	\$0	\$1,000,683	1.369	\$1,370,398	\$1.43
FQHC / RHC	\$280,556	\$1,195	\$8,461	\$20,743	\$310,955	1.369	\$425,841	\$0.45
Home Health	\$93	\$0	\$0	\$5	\$98	1.192	\$117	\$0.00
IP - Maternity	\$814,062	\$2,205	(\$52,350)	\$6,485	\$770,402	1.242	\$957,079	\$1.00
IP - Newborn	\$797,443	\$2,160	(\$51,281)	\$2,428	\$750,749	1.242	\$932,664	\$0.98
IP - Other	\$9,751,388	\$26,408	(\$619,595)	\$37,560	\$9,195,761	1.242	\$11,424,002	\$11.95
IP - Psych	\$819,596	\$0	(\$36,414)	\$4,890	\$788,071	2.887	\$2,275,187	\$2.38
Lab	\$1,789,069	\$3,426	\$0	\$219,727	\$2,012,221	1.217	\$2,447,946	\$2.56
OP - Emergency Room	\$3,461,813	\$15,612	\$0	\$169,735	\$3,647,160	1.192	\$4,346,497	\$4.55
OP - Other	\$14,503,693	\$65,407	\$0	\$189,225	\$14,758,326	1.192	\$17,588,212	\$18.40
Pharmacy	\$19,268,728	\$14	(\$655,317)	\$1,285,232	\$19,898,658	1.251	\$24,883,618	\$26.04
Prof - Anesthesia	\$757,280	\$3,224	\$15,449	\$0	\$775,954	1.369	\$1,062,640	\$1.11
Prof - Child EPSDT	\$2,847,723	\$12,125	\$58,096	\$0	\$2,917,945	1.369	\$3,996,017	\$4.18
Prof - Evaluation & Management	\$18,765,643	\$74,799	\$1,123,648	\$1,048,727	\$21,012,817	1.348	\$28,333,508	\$29.64
Prof - Maternity	\$441,287	\$1,879	\$0	\$1,111	\$444,277	1.369	\$608,421	\$0.64
Prof - Other	\$5,309,414	\$22,090	\$108,307	\$230,812	\$5,670,623	1.362	\$7,720,890	\$8.08
Prof - Psych	\$1,488,861	\$4,415	\$30,335	\$101,241	\$1,624,852	1.267	\$2,058,201	\$2.15
Prof - Specialist	\$2,448,449	\$10,425	\$53,952	\$59,539	\$2,572,365	1.369	\$3,522,758	\$3.69
Prof - Vision	\$1,053,502	\$1,065	\$21,423	\$47,648	\$1,123,637	1.105	\$1,241,960	\$1.30
Radiology	\$922,538	\$2,812	\$0	\$119,841	\$1,045,192	1.323	\$1,383,274	\$1.45
Transportation/Ambulance	\$308,800	\$941	\$0	\$4,161	\$313,902	1.323	\$415,437	\$0.43
Provider Incentive Payment Adjustment								\$3.57
Total	\$86,875,941	\$254,657	(\$45,058)	\$3,549,108	\$90,634,648		\$116,994,669	\$125.98

Virginia Medicaid
FY 2010 Capitation Rate Development
Health Plan Encounter Data
Summary of FY 2010 Base Capitation Rates Below & Above 150% Federal Poverty Level

Section I
Exhibit 5a

Age Group	Combined Base Rates	Copay Value PMPM FAMIS <=150%	Copay Value PMPM FAMIS >150%	Admin Cost Adjustment	State Budget Cap Adjustment	Statewide		
						FAMIS <=150% Total with Admin	FAMIS >150% Total with Admin	
Under 1	\$286.56	\$1.92	\$4.61	7.29%	-16.09%	\$257.61	\$255.17	
1-5	\$123.58	\$1.99	\$4.85	7.29%	-16.09%	\$110.04	\$107.45	
6-14	\$104.53	\$2.02	\$4.96	7.29%	-16.09%	\$92.77	\$90.12	
Female 15-18	\$191.93	\$2.05	\$4.97	7.29%	-16.09%	\$171.85	\$169.20	
Male 15-18	\$136.02	\$2.05	\$5.01	7.29%	-16.09%	\$121.24	\$118.56	
						Overall FAMIS		
Average						\$111.90	\$109.05	\$109.73

Note: Average is based on health plan enrollment distribution as of February 2009.

Virginia Medicaid
FY 2010 Capitation Rate Development
Health Plan Encounter Data
Comparison of FAMIS Capitation Rates FY 2009 v. FY 2010

Section I
Exhibit 5b

		Statewide					
Aid Category		FAMIS <=150%			FAMIS >150%		
	Age Group	FY 2009	FY 2010	% Difference	FY 2009	FY 2010	% Difference
FAMIS	Under 1	\$277.54	\$257.61	-7.18%	\$274.16	\$255.17	-6.93%
	1-5	\$107.81	\$110.04	2.07%	\$104.46	\$107.45	2.86%
	6-14	\$83.79	\$92.77	10.72%	\$80.40	\$90.12	12.08%
	Female 15-18	\$159.73	\$171.85	7.59%	\$156.25	\$169.20	8.29%
	Male 15-18	\$116.93	\$121.24	3.69%	\$113.48	\$118.56	4.48%
Average		\$106.02	\$111.90	5.55%	\$102.38	\$109.05	6.51%

Overall FAMIS Average		
FY 2009	FY 2010	% Difference
\$103.25	\$109.73	6.28%

Note: Average is based on health plan enrollment distribution as of February 2009.

**Virginia Medicaid
 FY 2010 Capitation Rate Development
 Health Plan Encounter Data
 February 2009 FAMIS Member Month Distribution**

**Section I
 Exhibit 5c**

Aid Category	Age Group	Statewide
FAMIS <= 150%	Under 1	294
	1-5	3,866
	6-14	5,463
	Female 15-18	1,002
	Male 15-18	940
Aid Category Total		11,565
FAMIS >150%	Under 1	934
	1-5	12,214
	6-14	17,712
	Female 15-18	3,153
	Male 15-18	3,037
Aid Category Total		37,050
Total		48,615

Virginia Medicaid

FY 2010 Capitation Rate Development for FAMIS Moms Program

Health Plan Encounter Data

Historical Eligibility, Claims and Utilization - Program Designation 91 and FAMIS MOMS

Section II

Exhibit 1

Age 10 and Over Female												
Statewide	Raw Claims FY07	Raw Claims FY08	Capitation FY07	Capitation FY08	Unadjusted PMPM 07	Unadjusted PMPM 08	Units FY07	Units FY08	Units/1000 FY07	Units/1000 FY08	Cost/Unit FY07	Cost/Unit FY08
Member Months	135,067	142,678										
Service Type												
DME/Supplies	\$196,220	\$206,484	\$0	\$0	\$1.45	\$1.45	1,680	1,597	149	134	\$116.80	\$129.30
FQHC / RHC	\$836,616	\$955,986	\$0	\$0	\$6.19	\$6.70	12,248	14,565	1,088	1,225	\$68.31	\$65.64
Home Health	\$2,375	\$4,938	\$0	\$0	\$0.02	\$0.03	32	69	3	6	\$74.22	\$71.56
IP - Maternity	\$43,590,737	\$44,479,217	\$0	\$0	\$322.73	\$311.75	16,299	16,996	1,448	1,429	\$2,674.44	\$2,617.04
IP - Newborn	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	0	0	-	-
IP - Other	\$1,306,943	\$1,556,396	\$0	\$0	\$9.68	\$10.91	303	313	27	26	\$4,313.34	\$4,972.51
IP - Psych	\$100,902	\$200,605	\$85,328	\$93,675	\$1.38	\$2.06	259	382	23	32	\$719.03	\$770.37
Lab	\$894,318	\$1,239,114	\$102,692	\$95,179	\$7.38	\$9.35	123,766	134,969	10,996	11,352	\$8.06	\$9.89
OP - Emergency Room	\$1,713,075	\$2,172,196	\$0	\$0	\$12.68	\$15.22	6,968	7,378	619	621	\$245.85	\$294.42
OP - Other	\$10,467,033	\$11,742,473	\$0	\$0	\$77.50	\$82.30	37,681	41,908	3,348	3,525	\$277.78	\$280.20
Pharmacy	\$3,760,856	\$4,067,259	\$0	\$0	\$27.84	\$28.51	130,003	142,155	11,550	11,956	\$28.93	\$28.61
Prof - Anesthesia	\$3,583,264	\$3,797,461	\$0	\$0	\$26.53	\$26.62	15,257	16,268	1,356	1,368	\$234.86	\$233.43
Prof - Child EPSDT	\$141,547	\$144,020	\$0	\$0	\$1.05	\$1.01	9,340	6,833	830	575	\$15.15	\$21.08
Prof - Evaluation & Management	\$4,199,095	\$4,937,744	\$200,829	\$231,128	\$32.58	\$36.23	71,744	80,208	6,374	6,746	\$61.33	\$64.44
Prof - Maternity	\$22,533,916	\$24,209,130	\$0	\$0	\$166.84	\$169.68	45,200	46,460	4,016	3,908	\$498.54	\$521.07
Prof - Other	\$1,224,921	\$1,643,647	\$15,853	\$18,611	\$9.19	\$11.65	55,584	63,347	4,938	5,328	\$22.32	\$26.24
Prof - Psych	\$112,561	\$121,591	\$96,657	\$111,657	\$1.55	\$1.63	2,758	3,120	245	262	\$75.86	\$74.76
Prof - Specialist	\$1,639,289	\$1,655,992	\$0	\$0	\$12.14	\$11.61	16,146	17,760	1,434	1,494	\$101.53	\$93.24
Prof - Vision	\$17,349	\$23,173	\$120,097	\$131,390	\$1.02	\$1.08	2,002	2,398	178	202	\$68.65	\$64.46
Radiology	\$2,923,576	\$3,478,813	\$0	\$0	\$21.65	\$24.38	37,848	43,562	3,363	3,664	\$77.25	\$79.86
Transportation/Ambulance	\$415,560	\$441,779	\$323,125	\$331,706	\$5.47	\$5.42	13,863	16,131	1,232	1,357	\$53.28	\$47.95
Total	\$99,660,154	\$107,078,019	\$944,581	\$1,013,347	\$744.85	\$757.59	598,981	656,419				

Virginia Medicaid
FY 2010 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS and Program Designation 91
Pharmacy Adjustment

Section II
Exhibit 2a

	FAMIS MOMS	Source
1. Health Plan Total Drug Cost PMPM	\$28.18	FY07-FY08 Health Plan Encounter Data
2. Average Managed Care Rebate	3.6%	From Plan Data
3. Adjusted PMPM with Managed Care Rebate	\$27.18	= (3.) * (1 - (2.))
4. Average PBM Admin Cost PMPM	\$0.13	From Plan Data
5. Adjusted PMPM with Pharmacy Pricing Arrangements	\$27.31	= (3.) + (4.)
6. Pharmacy Adjustment	-3.1%	= (5.) / (1.) - 1

Virginia Medicaid
FY 2010 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS and Program Designation 91
Pediatric E&M Fee Increase Adjustment

Section II
Exhibit 2b

		FAMIS MOMS	Source	
1.	FY07 Claims Associated with Pediatric E&M Procedure Codes for Children	a. FQHC / RHC b. Prof - Evaluation & Management	\$22,060 \$886,100	FY07 Health Plan Encounter Data
2.	% Fee Increase Effective FY08 for Children		10%	Provided by DMAS
3.	Dollar Increase	a. FQHC / RHC b. Prof - Evaluation & Management	\$2,206 \$88,610	= (1.) * (2.)
4.	Total claims in Service Category	a. FQHC / RHC b. Prof - Evaluation & Management	\$1,792,602 \$9,568,796	FY07-FY08 Health Plan Encounter Data
5.	Pediatric E&M Fee Increase Adjustment	a. FQHC / RHC b. Prof - Evaluation & Management	0.1% 0.9%	= (3.) / (4.)

Virginia Medicaid
FY 2010 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS and Program Designation 91
Professional Fee Increase Adjustment (Excluding Pediatric E&M and OB-GYN services)

Section II
Exhibit 2c

		FAMIS MOMS	Source
1. Claims Associated with Professional Services*	a. Prof - Evaluation & Management	\$3,778,818	FY07-FY08 Health Plan Encounter Data
	b. Prof - Specialist	\$785,762	
	c. All Other Professional Categories	\$5,312,250	
2. % Fee Increase Effective FY08		5%	Provided by DMAS
3. Dollar Increase	a. Prof - Evaluation & Management	\$188,941	= (1.) * (2.)
	b. Prof - Specialist	\$39,288	
	c. All Other Professional Categories	\$265,613	
4. Total claims in Service Category	a. Prof - Evaluation & Management	\$9,568,796	FY07-FY08 Health Plan Encounter Data
	b. Prof - Specialist	\$3,295,281	
	c. All Other Professional Categories	\$11,303,802	
5. Professional Fee Increase Adjustment	a. Prof - Evaluation & Management	2.0%	= (3.) / (4.)
	b. Prof - Specialist	1.2%	
	c. All Other Professional Categories	2.3%	

* Note:

Claims associated with OB-GYN and Pediatric E&M procedure codes have been excluded from this adjustment.

Virginia Medicaid
FY 2010 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS and Program Designation 91
Exempt Infant Formula Carveout Adjustment

Section II
Exhibit 2d

	FAMIS MOMS	Source
1. Claims Associated with Exempt Infant Formula for Children	\$1,452	FY07-FY08 Health Plan Encounter Data
2. Total Claims in DME/Supplies Service Category	\$402,704	FY07-FY08 Health Plan Encounter Data
3. Exempt Infant Formula Carveout Adjustment	-0.4%	= (1.) / (2.)

Virginia Medicaid
FY 2010 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS and Program Designation 91
Hospital Inpatient Adjustments

Section II
Exhibit 2e

	Inpatient Medical/Surgical	Inpatient Psychiatric	Source
1. FY07 Hospital Inpatient Operating Adjustment Factor	78.0%	78.0%	Provided by DMAS
FY08 Hospital Inpatient Operating Adjustment Factor	78.0%	84.0%	
2. FY07 Inpatient Claims	\$44,897,680	\$186,230	FY07-FY08 Health Plan Encounter Data
FY08 Inpatient Claims	\$46,035,613	\$294,280	
3. FY07-FY08 Hospital Inpatient Operating Adjustment Factor	78.0%	81.7%	Weighted Average of FY07 - FY08
4. FY09 Hospital Inpatient Operating Adjustment Factor	78.0%	84.0%	Provided by DMAS
5. FY09 Hospital Rate Reduction	2.7%	2.7%	Provided by DMAS
6. FY10 Hospital Rate Reduction	4.0%	4.0%	Provided by DMAS
7. FY09 Hospital Capital Percentage	10.0%	10.0%	Provided by DMAS
8. FY10 Capital Reimbursement Reduction for Private Hospitals	6.3%	6.3%	Provided by DMAS
9. % Excluded Claims from Exempt Hospitals*	13.0%	9.6%	FY07-FY08 Health Plan Encounter Data
10. Hospital Inpatient Adjustment	-6.5%	-4.1%	$= (((4.) * (1 - (5.)) * (1 - (6.))) / (3.)) * (1 - (7.))$ $+ ((7.) * (1 - (9.)) * (1 - (8.)) + (7.) * (9.) - 1)$

*Exempt hospitals are CHKD, UVA, and MCV.

Virginia Medicaid
FY 2010 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS and Program Designation 91
Rural Wage Index Adjustment

Section II
Exhibit 2f

	FAMIS MOMS	Source
1. Estimated Impact of Adjustment	\$536,604	Provided by DMAS
2. Total Claims in IP - Other Service Category	\$332,442,606	FY07-FY08 Medallion II Health Plan Encounter Data
3. Proportion of Claims to be Adjusted	47%	FY07 Medallion II Health Plan Encounter Data
4. Rural Wage Index Adjustment	0.1%	= (1.) / (2.) * (3.)

Virginia Medicaid
FY 2010 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS and Program Designation 91
Provider Incentive Payment Adjustment

Section II
Exhibit 2g

	Adjustment Value	Source
Provider Incentive Payment Adjustment	0.5%	From Plan Data

Virginia Medicaid
FY 2010 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS and Program Designation 91
Administrative Cost Adjustment

Section II
Exhibit 2h

	FAMIS MOMS	Source
1. Claims Adjustment Expense PMPM	\$7.52	Expense from CY2008 BOI Reports; Member months from capitation payment files
2. General Admin Expense PMPM	\$44.09	Expense from CY2008 BOI Reports; Member months from capitation payment files
3. Claims Adjustment Expense Increase %	1.8%	BLS CPI-U
4. General Admin Expense Increase %	2.7%	Weighted average of BLS Compensation Trend and CPI
5. Administrative PMPM*	\$53.60	= (1.) * (1+ (3.))^(18 months/12) + (2.) * (1+ (4.))^(18 months/12)
6. Adjusted and Trended Base PMPM	\$760.39	Weighted average of medical component of FY2010 MedII Base Rates
7. Administrative allowance as % of Base Capitat	6.54%	= (5.) / ((5.) + (6.)) / (1 - 0.75%)
8. Contribution to Reserves as % of Base Capitat	0.75%	Provided by DMAS
9. Administrative Factor as % of Base Capitatic	7.29%	= (7.) + (8.)

*Note:

Administrative increases are applied from midpoint of CY2008 to the midpoint of the contract period (18 months) using compound interest calculations.

Virginia Medicaid
FY 2010 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS and Program Designation 91
Trend and Incurred But Not Reported (IBNR) Adjustments

Section II
Exhibit 3

Category of Service	Age 10 and Over Female							
	Completion and Policy/Program Adjustments			Data Period Trend			Contract Period Cost and Utilization Trend	Total Trend Factor
	IBNR	Policy/Program ¹	Total Base Data Adjustments	Cost Trend	Utilization Trend	Cost and Utilization Trend		
Inpatient Medical/Surgical	0.3%	-6.5%	-6.2%	-1.7%	-0.7%	-2.4%	0.0%	0.9760
Inpatient Psychiatric	0.0%	-4.1%	-4.1%	27.4%	-2.6%	24.1%	4.3%	1.3217
Outpatient Hospital	0.5%	0.0%	0.5%	3.6%	3.6%	7.3%	5.4%	1.1610
Practitioner	0.5%	0.8%	1.3%	-6.3%	4.9%	-1.6%	0.2%	0.9870
Prescription Drug	0.0%	-3.1%	-3.1%	-1.4%	3.7%	2.2%	4.4%	1.0905
Other	0.5%	0.0%	0.5%	8.0%	10.4%	19.3%	11.3%	1.4004
Weighted Average*	0.4%	-2.7%	-2.3%	-2.1%	2.6%	0.5%	1.5%	1.0302

Months of Trend Applied	12	12	12	18
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¹ The Policy and Program Adjustments are summarized in this table as weighted averages and are applied at the rate cell level in Exhibit 4.

² Weighted averages for Completion and Program Adjustments are calculated using a distribution by Service Type, before Trend and Adjustments (Total Claims FY07-FY08), whereas weighted averages for Trends are calculated using a distribution by Service Type, before Trend (Adjusted FY07-FY08 Claims)

Trend rates for managed care plans are calculated based on regression studies of historical health plan data.

Trend rates have been calculated separately for the broad service categories shown above. Utilization trend is based on service units per thousand.

Inpatient contract period trend included consideration of cost per unit projections provided by DMAS.

Data period trends are applied from the midpoint of the data period to the end of the data period using compound interest calculations. Contract period trends are applied from the end of the data period to the midpoint of the contract period using compound interest calculations.

Total Trend = [(1 + data period trend) ^ (months/12) * (1 + contract period trend) ^ (months/12)]

Virginia Medicaid
FY 2010 Capitation Rate Development for FAMIS Moms Program
Capitation Rate Calculations - Health Plan Encounter Data
Program Designation 91 and FAMIS MOMS

Section II
Exhibit 4

Age 10 and Over Female							
Statewide	Total Claims FY07 - FY08	Completion Factor Adjustment	Policy and Program Adjustments ¹	Completed and Adjusted Claims FY07 - FY08	Trend/IBNR Adjustment FY07 - FY08	Completed & Trended Claims FY10	PMPM FY10
Service Type							
DME/Supplies	\$402,704	\$2,027	(\$1,459)	\$403,272	0.987	\$398,009	\$1.43
FQHC / RHC	\$1,792,602	\$9,022	\$2,217	\$1,803,840	0.987	\$1,780,302	\$6.41
Home Health	\$7,313	\$35		\$7,347	1.161	\$8,530	\$0.03
IP - Maternity	\$88,069,955	\$258,061	(\$5,734,157)	\$82,593,859	0.976	\$80,611,606	\$290.24
IP - Newborn	\$0	\$0		\$0	0.976	\$0	\$0.00
IP - Other	\$2,863,339	\$8,390	(\$184,232)	\$2,687,498	0.976	\$2,622,998	\$9.44
IP - Psych	\$480,509	\$0	(\$19,793)	\$460,717	1.322	\$608,910	\$2.19
Lab	\$2,331,304	\$11,175		\$2,342,479	1.400	\$3,280,491	\$11.81
OP - Emergency Room	\$3,885,271	\$18,552		\$3,903,823	1.161	\$4,532,374	\$16.32
OP - Other	\$22,209,506	\$106,051		\$22,315,557	1.161	\$25,908,562	\$93.28
Pharmacy	\$7,828,115	\$85	(\$243,827)	\$7,584,372	1.091	\$8,271,081	\$29.78
Prof - Anesthesia	\$7,380,725	\$37,145	\$174,302	\$7,592,173	0.987	\$7,493,104	\$26.98
Prof - Child EPSDT	\$285,568	\$1,437	\$6,744	\$293,749	0.987	\$289,916	\$1.04
Prof - Evaluation & Management	\$9,568,796	\$48,157	\$278,948	\$9,895,901	0.987	\$9,766,771	\$35.16
Prof - Maternity	\$46,743,046	\$235,246		\$46,978,292	0.987	\$46,365,279	\$166.93
Prof - Other	\$2,903,033	\$14,610	\$68,558	\$2,986,201	0.987	\$2,947,235	\$10.61
Prof - Psych	\$442,466	\$2,227	\$10,449	\$455,142	0.987	\$449,203	\$1.62
Prof - Specialist	\$3,295,281	\$16,584	\$39,486	\$3,351,351	0.987	\$3,307,620	\$11.91
Prof - Vision	\$292,009	\$1,470	\$6,896	\$300,375	0.987	\$296,455	\$1.07
Radiology	\$6,402,389	\$30,691		\$6,433,080	1.400	\$9,009,114	\$32.44
Transportation/Ambulance	\$1,512,170	\$7,249		\$1,519,419	1.400	\$2,127,848	\$7.66
Provider Incentive Payment Adjustment							\$4.03
Total	\$208,696,101	\$808,214	(\$5,595,867)	\$203,908,447		\$210,075,407	\$760.39
Admin Cost Adjustment							\$59.75
FAMIS MOMS Capitation Rate							\$820.14

¹ Policy and Program Adjustments are calculated based on Completed Claims = Total Base Claims + Completion Factor Adjustment.

Virginia Medicaid
FY 2010 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - Program Designation 91 and FAMIS MOMS
Summary of FY 2010 Capitation Rate

Section II
Exhibit 5a

Aid Category	Age Group	Statewide
FAMIS MOMS	Age 10 and Over Female	\$820.14

Virginia Medicaid
FY 2010 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - Program Designation 91 and FAMIS MOMS
Comparison of FY 2009 and FY 2010 Capitation Rates

Section II
Exhibit 5b

Aid Category	Age Group	Statewide		
		FY 2009*	FY 2010	% Change 2009-2010
FAMIS MOMS	Age 10 and Over Female	\$938.71	\$820.14	-12.63%

FFS Payment Adjustment Effect: \$13.25 1.41%

*FY 2009 published rate.

**Virginia Medicaid
 FY 2010 Capitation Rate Development
 Health Plan Encounter Data
 State Budget Cap (FAMIS and FAMIS MOMS combined)**

**Section III
 Exhibit 1a**

	PMPM			% Change		
	FAMIS	FAMIS MOMS	Weighted Average	FAMIS	FAMIS MOMS	Weighted Average
1. FY 2009 Average Rate Weighted by Feb 2009 MM	\$103.25	\$938.71	\$119.87			
2. FY 2010 Average Rate before FFS Payment Adjustments and State Budget Cap	\$131.52	\$833.39	\$145.49	27.38%	-11.22%	21.37%
3. FY 2010 Average Rate with FFS Payment Adjustments Only	\$130.77	\$820.14	\$144.49	26.66%	-12.63%	20.54%
4. FFS Payment Adjustment Effect	\$0.75	\$13.25	\$0.99	0.72%	1.41%	0.83%
5. FY 2010 Average Rate with State Budget Cap for FAMIS only*	\$109.73			6.28%		
6. FY 2010 Average Rate with State Budget Cap on FAMIS and FAMIS MOMS combined	\$113.20	\$820.14	\$127.27	9.64%	-12.63%	6.17%

*FY 2010 state budget is capped at 7% increase less the value of FFS payment adjustments.

Virginia Medicaid
FY 2010 Capitation Rate Development
Health Plan Encounter Data
Summary of FY 2010 Base Capitation Rates Below & Above 150% Federal Poverty Level

Section III
Exhibit 1b

Age Group	Combined Base Rates	Copay Value PMPM FAMIS <=150%	Copay Value PMPM FAMIS >150%	Admin Cost Adjustment	State Budget Cap Adjustment	Statewide		Overall FAMIS
						FAMIS <=150% Total with Admin	FAMIS >150% Total with Admin	
Under 1	\$286.56	\$1.92	\$4.61	7.29%	-13.44%	\$265.76	\$263.24	
1-5	\$123.58	\$1.99	\$4.85	7.29%	-13.44%	\$113.52	\$110.85	
6-14	\$104.53	\$2.02	\$4.96	7.29%	-13.44%	\$95.71	\$92.97	
Female 15-18	\$191.93	\$2.05	\$4.97	7.29%	-13.44%	\$177.29	\$174.56	
Male 15-18	\$136.02	\$2.05	\$5.01	7.29%	-13.44%	\$125.08	\$122.32	
Average						\$115.44	\$112.50	\$113.20

Note: Average is based on health plan enrollment distribution as of February 2009.

Virginia Medicaid
FY 2010 Capitation Rate Development
Health Plan Encounter Data
Comparison of FAMIS Capitation Rates FY 2009 v. FY 2010

Section III
Exhibit 1c

		Statewide					
Aid Category		FAMIS <=150%			FAMIS >150%		
	Age Group	FY 2009	FY 2010	% Difference	FY 2009	FY 2010	% Difference
FAMIS	Under 1	\$277.54	\$265.76	-4.24%	\$274.16	\$263.24	-3.98%
	1-5	\$107.81	\$113.52	5.30%	\$104.46	\$110.85	6.11%
	6-14	\$83.79	\$95.71	14.23%	\$80.40	\$92.97	15.63%
	Female 15-18	\$159.73	\$177.29	10.99%	\$156.25	\$174.56	11.72%
	Male 15-18	\$116.93	\$125.08	6.97%	\$113.48	\$122.32	7.79%
Average		\$106.02	\$115.44	8.89%	\$102.38	\$112.50	9.88%

Overall FAMIS Average		
FY 2009	FY 2010	% Difference
\$103.25	\$113.20	9.64%

Note: Average is based on health plan enrollment distribution as of February 2009.